



REQUEST TO COPY PROTECTED HEALTH INFORMATION

Patient Name: _____

Acct #: _____

Date of Birth: _____

Patient Address: _____

Street

Apartment #

City, State, Zip

Send medical record to (if different from above):

Name

Street

City, State, Zip

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY: