



**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:**