Lifeline Medical Associates

Request to Inspect and Copy Protected Health Information

Patient Name: ______________________ Date of Birth: ______________________

Patient Address: ______________________________
Street

____
Apartment #

____
City, State Zip

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is one dollar ($1.00) per page, with a maximum charge of one hundred ($100.00) and an additional charge of fifteen dollars $15.00 if records need to be retrieved from storage or microfilm.

______________________________ ______________________________
Signature of Patient or Legal Guardian Date

____
Print Name of Patient or Legal Guardian

Destination for Desired Records

Facility/Doctor Name ______________________________

Address: ______________________________

____

____