



**REQUEST TO INSPECT AND COPY  
PROTECTED HEALTH INFORMATION**

PATIENT NAME: Robert L. Smith

DATE OF BIRTH: 3/2/43

PATIENT ADDRESS:

STREET: 4506 45th WY

APARTMENT #:

CITY, ST ZIP: Mangonia Park, FL 33407

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 \$\_\_\_\_\_ per page, with a minimum charge of \$\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

Date: 12/30/12

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY: