"Commitment to Excellence – Spirit of Service"

PATIENT REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMTION

Patient Name: _____ Chart Number: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____ Home Phone: _____

Work Phone: _____

West Georgia Eye Care Center will copy your medical records for you at your request. I agree to pay the cost of copy, $.63 per page for documents and the cost of mailing (if required) the aforementioned records.

I hereby request a copy of my medical record or other recorded Protected Health Information (PHI) as designated below:

_____

_____

_____

Mail a copy of the records requested to me at the above address or as designated below:

_____

_____

_____

_____ _____

Signature of Patient or Legal Representative Date