NEIL A. PATTERSON, M.D., P.A.

REQUEST TO INSPECT AND/OR 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 a fee of $5.00 associated with my request for a copy of my medical record which covers the cost of supplies, labor and postage related to the production of my information.

__________________________________ ______________________________
Signature of Patient or Legal Guardian Date

____
Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY:

Date Request Received:___________

For informational purposes only, please indicate below your reason for transferring your records. Thank you.

- ☐ **Relocation**
- ☐ **Change of Insurance**
- ☐ **New physician is closer to home**
- ☐ **Dissatisfied with customer service**