

**FLORIDA INFECTIOUS DISEASE GROUP, P.A.**

1012 Lucerne Terrace Orlando FL, 32806

Phone: 407-423-1039 Fax: 407-425-2347

**PATIENT REQUEST TO INSPECT AND OBTAIN A COPY  
OF PROTECTED HEALTH INFORMATION**

**Patient to complete the following information**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand 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 \$1.00 per pages for the first 25 pages and 25 cents per page thereafter.

\_\_\_\_\_  
Signature of patient or legal Guardian

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed name of patient or Legal Guardian

\_\_\_\_\_  
Records to be mailed or picked up

***For office use only:***

***Records pulled/copied by:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

***Records sent via mail or patient pickup:*** \_\_\_\_\_

***Total copying fee:*** \_\_\_\_\_ ***Collected:*** \_\_\_\_\_