

*Attention parent: To obtain a copy of your child's medical records, please complete this form and fax or mail it your current practice. Please note that you may have to call your current practice to see if there is a fee to complete this request.*

**REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION (PHI)**

I am requesting the following information be copied (check one):

entire chart

the following documents: \_\_\_\_\_

When the records are available, please (check one):

notify me at the following telephone number \_\_\_\_\_

mail the records to the following address

\_\_\_\_\_  
\_\_\_\_\_

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 \$\_\_\_\_\_.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian  
(or patient)

\_\_\_\_\_  
Print name of Legal Guardian  
(or patient)

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

\_\_\_\_\_  
**parent**  
Relationship to Patient