

YAFFE, RUDEN & ASSOCIATES, LLP

REQUEST TO INSPECT AND 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 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 \$5 for 1 to 10 pages and \$10 for anything over 10 pages.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian