# NORTHEAST ORTHOPAEDICS
## REQUEST TO INSPECT OR RECEIVE A COPY OF 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 $ .75 per page. I also understand NEO has up to 10 days to respond to this request.

__________________________________ ____________________________
Signature of Patient or Legal Guardian Date

__________________________________
Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY:

Date Request Received: ___________

# of pages copied ______

Total cost ______

Payment made ____cash ____credit card