REQUEST TO COPY PROTECTED HEALTH INFORMATION

Patient Name: ____________________________ DOB: __________________

Street Address: __________________________________
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 based on a fee schedule determined by the State of Ohio and is as follows:

Handling Fee:	$15.00
Copying pages 1 – 10:	$1.00 per page
Copying pages 11 – 50:	$0.50 per page
Copying pages over 50:	$0.20 per page
Postage Fee:	Exact postage

___________________________________ __________________
Signature of Patient or Guardian Date

____
Print Name of Legal Guardian

For Internal Use Only:

Date Request Received:	_________________	By:	__________
Approved by Privacy Officer:	_________________	Date:	__________
Number of pages copied:	_________________	Fee:	$_________
Date mailed (or called to pick up)	_________________	By:	__________