REQUEST TO INSPECT *AND / OR* COPY PROTECTED HEALTH INFORMATION

Patient Name: ____ Date of Birth: ______________________

Patient Address: ____
Street

____
Apartment #

____
City, State, Zip

- ❑ **SPECIFIC** INFORMATION REQUESTED (included dates):
____
____

- ❑ REQUEST TO INSPECT AND COPY

I understand and agree that I am financially responsible for the following fees associated with my request, per Michigan statute MCLA 333.26269: copying charges, including the cost of supplies and labor, and postage related to the production of my information. **All fees must be paid prior to the release of the PHI.**

- Initial fee for request………………………. …… **$n/a**
- $1.19 per page for the first 20 pages……… ________
- 60 cents per page for pages 21 through 50….. ________
- 23 cents per page for pages 51 and over… ________
- postage / shipping costs……………………….. ________
- *LESS FEE PAID*……………………………………… -________

TOTAL ________

____
Print Name of Patient *OR* Legal Representative

____ ____________________
Signature of Patient *OR* Legal Representative **Date**

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FOR OFFICE USE ONLY

FOR INTERNAL PURPOSES ONLY:

Date Request Received: ________________

- ❑ **INSPECTION SCHEDULED ON :** ____________________________@ ______________.

☐ **Record of Information Copied**

The following patient health information (PHI) was copied and provided to the patient identified above:

____

____

____________________________ ____________________________ ______________

employee name **employee signature** **date**