# Internal Medicine of Ithaca, PC

2359 N Triphammer Road, Ithaca, NY 14850

## Request to Inspect and Copy Protected Health Information

Patient Name:______________________________ Date of Birth:_________________________

Patient 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 $ 0.75 per page, with a minimum charge of $10.

______________________________________ _______________________

Signature of Patient or Legal Guardian Date

______________________________________

Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY: