



Twelve Corners Pediatrics

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www.twelvecornerspeditrics.com

REQUEST FOR COPY OF PROTECTED HEALTH INFORMATION TO TWELVE CORNERS PEDIATRICS

Patient Name: _____ DOB: _____
(Please Print)

Patient Address: _____

Previous Office Name: _____

Fax Number: _____

Patient/Parent day phone: () _____

I request a copy of my protected health information. I want a copy of:
(Please choose one)

- 1) A summary of my medical record: _____
- 2) Only that part of my medical record that relates to: _____

Release information to: **Twelve Corners Pediatrics**
 1815 South Clinton Avenue
 Building 300 Suite 310
 Rochester, NY 14618

Signature of Patient or Personal Representative (If under age 18)

Date: _____