Twelve Corners Pediatrics

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www.twelvecornerspediatrics.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

_____ *Date:* _____
Signature of Patient or Personal Representative (If under age 18)