# *ACCESS TO PROTECTED HEALTH INFORMATION REQUEST FORM QUAKER RIDGE FOOT CARE*

*I, _____, request access to the following protected health information contained in my medical record:*

_____

_____

_____

*(Please specify the information you wish to access by description, dates, etc.)*

*I would like to:*

_____ *pick up the copy*

_____ *have the copy mailed to:* _____

_____

_____

_____ *Review the copy at the office*

*I understand that I may be responsible for a copying fee and/or postage costs if applicable.*

_____

*Signature of Patient or Legal Guardian*

_____

*Print Name of Patient*

_____

*Date*