# Northwest Georgia Surgical Specialists, PC

## Request to Inspect and Copy Protected Health Information

Patient Name _____

Date of Birth _____

Patient Address _____
Street

_____
Apartment #

_____
City, State, Zip

I understand and agree that I am financially responsible for the following fees associated with my request for Protected Health Information: 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 $0.20 per page, with a minimum charge of $10.00.

_____
Signature of Patient or Legal Guardian

_____
Printed Name of Patient or Legal Guardian

_____
Date