LIFETIME INSIGHT

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REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Patient Address: _____
Street and Apartment Number

_____
City, State, Zip

I understand and agree that I am financially responsible for fees associated with my request ($0.50 per page, and a handling fee that will not exceed $20).

_____
(Signature of Patient) (Date)

OR

_____
(Signature of guardian or authorized representative) (Relationship to patient)