



NEW ENGLAND
ORTHOPEDIC SURGEONS

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HIPAA Request to Access Protected Health Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Please specify the type of request:

Request Inspection _____

Request Copy _____

Please note that we are unable to release any medical records received from other physicians. You must obtain those records from the physician who provided the service.

Please specify the requested information:

I understand and agree that I am financially responsible for the copying charges (cost of supplies and labor) associated with my request and I understand that the charge for this service is **\$15.00**.

Signature of Patient or Legal Guardian _____

Date: _____