CHILDREN'S OF ALABAMA
REQUEST TO REVIEW AND/OR COPY PROTECTED HEALTH INFORMATION

Patient Information

Patient Name: (Please print)		Request Date:	
Street Address:		Birth Date:	
City/State/ZIP:		Date of Service:	

Type of Request (please check as applicable)

☐ Review (Access, Inspect)	I wish to review the patient's medical records for my personal inspection. If I have any medical questions during my review, I will ask the patient's healthcare provider.
☐ Copy	I authorize Children's of Alabama to make copies of the patient's medical records. I agree to be responsible for the costs of copying these records, including copying fees, labor, supplies, and postage, as applicable. The reproduction charge is not more than one dollar ($1) for each page for the first 25 pages, and not more than 50 cents ($.50) for each page in excess of 25 pages, and a search fee of five dollars ($5). Alabama Code, Section 12-21-6.1 (1994). I agree to pay for the copies prior to the service being rendered.

Signature of Parent/Legal Guardian/Patient

I represent that I am the parent/legal guardian/patient and I have the authority to make this request.

Parent/Legal Guardian Signature:____Date:___________

Patient Signature if 14 or older:____Date:___________

Witness Signature:____Date:___________

INTERNAL USE ONLY
MIS Comments:____

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Req to Review/Copy Form 1b
Written: 3/03; Revised: 12/06; Revised: 12/14