

Dr. David R. Winchester, D.M.D., P.C.
Request For Patient Healthcare Information

This form is to request protected healthcare information which you maintain on patient

_____. Please
provide this information in the form of

photocopies

other media, _____

specify media requested

Please mail the resulting information to me at this address:

_____ State _____ ZIP _____

Please, contact me when the information is ready and I will arrange to pick it up at your office myself.

Please, contact me when the information is ready. I hereby authorize you to give it to

Mr. Ms. _____

or

Mr. Ms. _____

I understand that you cannot give this information to anyone other than me or the person(s) I have herein authorized to receive it.

I have read your Notice of Privacy Policies and I understand that I may be charged on a reasonable cost-based basis for all expenses incurred in honoring this request for information, including, but not limited to, a per-page copying cost, an hourly cost for staff time required to locate and copy the information, and mailing costs if I request that the information be mailed to me.

Signature _____ Date _____

If this form is signed by a personal representative of the patient, please, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

Mail or deliver the completed form to:

Dr. David R. Winchester
Suite 100
2500 Center Point Parkway
Center Point, AL 35215