

VALDOSTA STATE UNIVERSITY

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

- Speech Clinic
- Student Health Services
- Athletic Department
- Human Resources
- Other. Please Specify \_\_\_\_\_

Patient/Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient/Employee Address:

\_\_\_\_\_

Street

\_\_\_\_\_

Apartment #

\_\_\_\_\_

City, State Zip

I understand and agree that I am financially responsible for the following fees associated with my request: 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 \$1.00 per page.

\_\_\_\_\_  
Signature of Patient/Employee or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient/Employee or Legal Guardian

FOR INTERNAL PURPOSES ONLY:

Date Request Received: \_\_\_\_\_