

Erie County Medical Center Healthcare Network



“Patient’s Request”

To Review and / or Obtain Copies of Medical Information

Date: _____

Patient: _____ File # _____

Address: _____

Former Address: _____

Date of Birth: _____

Phone #: _____

Information requested: _____

I Herby request the opportunity to review medical information on the above named patient. I understand that if the patient is a minor child over the age of twelve, the patient may be informed of this request prior to granting the review. Furthermore, I am aware that the treating physician will be informed of this request. The treating physician may grant access to a prepared summary of this information if, in her/ his opinion, the review may endanger my life or physical safety, or may cause substantial harm to others. I am also aware, that I will be responsible for fees. The cost is \$.75 per page.

SIGNED: _____

DATE: _____

WITNESS SIGNATURE: _____

DATE: _____