



Twelve Corners Pediatrics

www.twelvecornerspeditrics.com

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REQUEST FOR COPY OF PROTECTED HEALTH INFORMATION

(Please

Patient _____ DOB: _____

Patient _____

Patient/Parent day
phone: (_____) _____

I request a copy of my protected health information. I want a copy of:
(please choose one)

- 1) A summary of my medical record: _____
- 2) Only that part of my medical record that relates to: _____

Release informaton
to: **Twelve Corners Pediatrics**
1815 South Clinton Avenue
Building 300 Suite 310
Rochester, NY 14618

Signature of Patient or Personal Representative (If under age 18)

Date: _____