

REQUEST FOR COPY OF PROTECTED HEALTH INFORMATION

PATIENT NAME: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_

\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

I hereby request a copy of my medical records. Please forward a copy to:

Stephen G. Sisselman, D.O., F.A.C.P.  
100 Veterans Boulevard  
Suite 2  
Massapequa, NY 11758  
Phone: 516-308-4040  
Fax: 516-804-6386

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

I am aware that I may be charged a maximum fee of \$0.75 per page, as per NYS law.

\_\_\_\_\_ Please copy my entire medical record

\_\_\_\_\_ Please copy my last EKG, BW, 3 office notes not to exceed \$10.00