

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