ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient 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:

*Copying Charges	$ .60 cents per page copied	_____
Microfiche Retrieval	$ 1.00 per page	_____
*Preparation Fee	$18.16	_____
*Postage	(Actual postage cost)	_____

TOTAL _____

* Maryland Code Annotated, Health General Article Section 4-309 (a), rates effective October 1, 2002.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name of Patient or Personal Representative

April 2003