# Request for Copy of Protected Health Information

## PACIFIC PEDIATRICS, LLC

**Information About the Patient Whose Records Are Being Requested:**

**Patient's Name: Last:_____First:_____MI:_____**
**Street Address:_____**
**City,State,ZipCode:_____**
**DateofBirth:_____ Phone Number: _____**

**FacilitySendingRecords:**

**Pacific Pediatrics, LLC PO Box 1732 Ward Cove, AK99928**
**Cell:313-300-8189, Fax:833-887-4972**

**FacilityReceivingRecords:**

**FacilityName:_____**
**FacilityAddress:_____**
**FacilityCity,State,ZipCode:_____**
**FacilityPhoneNumber:_____**
**FacilityFaxNumber:_____**

**Visit Date Range Needed (SelectOne):**

◯ **All**
◯**RecordsSpecific: (from)_____(to)_____**
◯**Other:_____**

**Requester:_____**
**Signature:_____**
**Date:_____**

**Relationship to Patient: ◯Patient (self) ◯Parent/*Legal Guardian ◯Other**

***Please attach proof of guardianship with this request.**

## OPTIONS FOR RETURNING THIS COMPLETED FORM:

**Fax: (833) 887-4972  Email: elisarosier@pacificpediatricsllc.com**

**Mail to: Pacific Pediatrics, LLC, PO Box 1732, Ward Cove, AK  99928**