

Signature of HIPAA Privacy Officer or designee

PINEVILLE

MIDTOWN

11940 Carolina Pl Pkwy, #200, Pineville, NC 28134 p 704.541.9080 | f 704.542.0699

4012 Park Road, #200, Charlotte, NC 28209 p 704.332.4834 | f 704.372.9653

Date

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		e:		Date of Birth:	
		(first name last na	•	(mm/dd/yy)	
Self			ent's representative:		
hone	e: Relationship of representative:				
reque	est cop	ies of the above name	ed client's medical record, as	described below. I understand these records co	ntair
rotec	ted He	alth Information (PHI)	. I understand this request f	form must be fully completed and signed in addit	ion
			·	I agree to be responsible for the cost of providin	
		escribed and selected	·	υ συν το	0
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REQUE	ESTED	DOCUMENTS:			
List s د	pecific	document(s):			
		· ·	plans and progress notes.		
				side records, and signed forms or documents.	
SELECT	r WHIC	CH RECORDS YOU ARE	REQUESTING:		
Occu	ıpation	nal Therapy records	o Ed	 Educational records 	
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