EXHIBIT F GUAM COMMUNITY HEALTH CENTERS (NORTHERN AND SOUTHERN REGION COMMUNITY HEALTH CENTERS)

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Address: Street	Patient Name:			Date of Birth:
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 services \$13.90 for on-island request and \$35.00 for off-island request. Print Name of Patient or Legal Guardian: Signature of Patient or Legal Guardian Date	Patient Address:			
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