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

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 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**

FOR INTERNAL PURPOSES ONLY: