

**ATLANTA COLON AND RECTAL SURGERY, PA**  
**REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION**

Account #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Street

\_\_\_\_\_  
Apartment #

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

Approved By: \_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date