

**MICHAEL REYNARD, M.D.**  
1301 – 20<sup>TH</sup> STREET #260  
**SANTA MONICA, CA 90404**

**REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION**

Date: \_\_\_\_\_

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

**We have received your request for copies of your medical records. We will copy and mail your medical records after you have signed this release and sent payment to our office of \$45, in accordance with Section 123110 of California Health & Safety Code.**

**If we do not receive this signed release and payment within thirty (30) days we will consider that you no longer request your records copied and sent.**

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

<p><b>Please send records to:</b></p> <p>_____</p> <p>_____</p> <p>_____</p>
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