

MEDICAL RECORDS REQUEST

I was a patient of DR. JEROME WEISS. I hereby request and authorize DR. JEROME WEISS and DataSafe Inc to release to me a copy of all of my medical records which DataSafe is storing for DR. JEROME WEISS and can readily be located. I acknowledge that such records may include protected health information on me, and may include records, documents and information about (a) my health and physical and/or mental condition including any diseases, addictions, instabilities, injuries, illnesses and diagnoses; (b) medications prescribed to me or which I have taken, and; (c) tests, lab reports, radiological images, and evaluations on me. Such records, documents and information may also contain notes and consultations by physicians and other healthcare providers.

I agree to pay the cost of retrieving and copying such medical records in accordance with applicable law. I further acknowledge that DataSafe is simply storing records for DR. JEROME WEISS and has played no part in organizing the files and is simply supplying to me the medical records on me that it can readily locate, which may not be all of the records that exist on me in the files of DR. JEROME WEISS.

I hereby swear or affirm that I am an adult, and that the information provided by me below is true accurate and correct.

Signature: _____ Print Name: _____

Date of Birth: _____

Social Security (last four): _____

Current Address: _____

State of California

County of _____)

On this _____ day of _____ 20 __, before me, the undersigned notary public, personally appeared _____, who proved to me through satisfactory evidence of identification, which was _____, to be the person whose name is signed on the preceding document, who swore or affirmed to me that the contents of the document are truthful and accurate to the best of his/her knowledge and belief.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ Commission Expiration Date of Notary Public _____

(Seal)