

FNA, P.C.
Request to Access and/or Copy Protected Health Information (PHI)

Section A: Individual to complete and sign first page only. (Please Print)

I am submitting a request to inspect and/or receive a copy my protected health information created by the Practice Site named below. I understand that I may be charged a reasonable cost-based fee for copying my records. Applicable mailing fees also may apply. I will receive the requested records within 30 days of my request. This Practice Site may extend this deadline by 30-days provided that I receive written notification of this extension. If the Practice Site does not maintain my health information, I will be informed where to direct my request.

1. Please check ✓ the Practice Site where you are requesting to access and/or inspect your medical records.

<input type="checkbox"/> Pediatric Lung Center (including: Allergy)	<input type="checkbox"/> Pediatric Infectious Disease Group
<input type="checkbox"/> Pediatric Sleep Center	<input type="checkbox"/> Pediatric Surgical Group
<input type="checkbox"/> Management Consultants for Affiliated Physicians, Inc	

Patient Name: _____
Last First Middle

Telephone #: _____ Patient's Date of Birth: _____

2. Please check the box indicating how would you like to receive the requested health records?

Mail to my current address: _____
Street Address City State Zip Code

Pick-up (you will be required to provide photo identification.) Please provide a phone number where we may contact you when copies are ready for pick up. _____

Review in person (you will be required to provide photo identification.) *Any review of patient records will be conducted in the presence of a clinical staff member.* Please provide a phone number where we may contact you to schedule an appointment. _____

3. Please check the box(es) indicating the types of records you would like to receive and the Date(s) of Services for those records.

<input type="checkbox"/> Demographic Sheet	<input type="checkbox"/> Diagnostic Imaging Reports	<input type="checkbox"/> Billing Statement
<input type="checkbox"/> Visit/Office Notes	<input type="checkbox"/> Pulmonary Function Test	<input type="checkbox"/> Other, describe: _____
<input type="checkbox"/> Consults	<input type="checkbox"/> Operative Notes	_____
<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Pathology Report	_____
<input type="checkbox"/> Sleep Study Results	<input type="checkbox"/> Sent Entire Medical Record	

Please provide the Date(s) of Service you would like records for: _____

 Signature of Patient or Patient's Personal Representative

 Date

 Print Name of Patient's Personal Representative (if applicable)

 Personal Representative's Relationship to Patient (if applicable)

Section B: For office use only

Medical Record Number: _____

_____(Name) Records mailed/picked up on _____ (date)

_____(Name) Records inspected on _____ (date)
(if applicable)

_____(Name) Sent notice of 30-day extension on _____ (date)
(if applicable)

_____(Name) Request denied on _____ (date)
(if applicable)

Reason for denial _____
(if applicable)