

FNA, P.C.
Outpatient Practice Sites instructions for completion of the
“Request to Access and/or Copy Protected Health Information” form

If you are requesting medical records to be released to yourself, or you are the personal representative for an individual, **complete Section A only**. Please legibly print information so we may accurately identify the patient. We will provide copies of medical records at no charge only when records are directed to another health care provider for treatment purposes.

Section A:

1. Check the box of the practice site where you are requesting a copy of or access to your medical records.
 - Print the full name of the patient, including middle initial.
 - Provide a contact phone number where we may contact you should we have any questions about your request.
 - Print the patient’s date of birth.
2. Please check one of the boxes to indicate how you would like to receive the requested information.
 - If you would like the records mailed to your current address, please provide your complete mailing address, including street address, city, state and zip code.
 - If you would like to personally pick up the records, please provide a contact phone number so we may contact you when they are ready to pick up. Please keep in mind that we will require photo identification before releasing the records to you.
 - If you would like to review the records in person, provide a contact phone number so we may contact you to set up an appointment. Please keep in mind that a clinical staff member must be present during your review of the records. We will also require photo identification before allowing you to review the requested records.
3. Please select those types of medical records you would like copies of. If a type of record is not listed, please provide a description of that record where it states, “Other”.
 - Please provide the Date(s) of Service or a date range for the requested records.

Sign your name if you are the patient or the patient’s personal representative on the “signature” line. Indicate the date you are signing the form. Print your name below the signature line. If applicable, write your relationship to the patient if you are not the patient.

If you have any questions regarding your request, please call the outpatient site where you received your services.

Pediatric Lung Center (703) 289-1410	Pediatric Infectious Disease (703) 226-2280
Pediatric Sleep Center (703) 226-2290	Pediatric Surgical Group (703) 560-2236

If you have questions regarding billing records, please contact MCAP at (703) 289-1400.