FNA P.C.
a Neonatal & Pediatric Subspecialty Group

Request to Review and/or Obtain a Copy of Protected Health Information (PHI)

Form Use: Patients and personal representatives must use this form to request access to, or a copy of, medical records.

Patient Name: _____
Last First Middle Other Name

Telephone #: _(_____)_____ **Date of Birth:** _____
Okay to leave a detailed message? ❒ Yes ❒ No

1. Check ✓ the site where you are requesting to review and/or obtain a copy of medical records.

❒ Fairfax Neonatal Associates (**FNA**)	❒ The Pediatric Lung Center & Allergy (**PLC**)	
❒ Pediatric Infectious Disease Group (**PIDG**)	❒ Pediatric & Adolescent Sleep Center (**PASC**)	❒ Pediatric Surgical Group (**PSG**)

2. In what format would you like the records?

☐ **Paper (All sites provide paper copies of medical records)**

☐ **USB Flash Drive (for PLC and PASC medical records requests only)**

3. Check the box indicating how you would like to receive the records and fill-in any requested information.

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

☐ **Pick-up** (you will be required to provide photo-identification at the time of pick-up). 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 at the time of the review). *Any review of patient records will be conducted in the presence of a FNA, P.C. employee.* Please provide a phone number where we may contact you to schedule an appointment. (_____)_____

4. Check the box(es) indicating the types of records you would like to receive and the date(s) of service for those records.

❒ Demographic Sheet	❒ Diagnostic Imaging Reports	❒ Billing Statement
❒ Visit/Office Notes	❒ Pulmonary Function Test	❒ Other, describe: _____
❒ Consults	❒ Operative Notes	_____
❒ Laboratory Reports	❒ Pathology Report	_____
❒ Sleep Study Results	❒ Send Entire Medical Record	

REQUIRED: Date(s) of service or date range of the records you are requesting: _____

Acknowledgements: I am submitting this form to request access to, or obtain a copy of, my or my minor child's medical records created by the practice site(s) checked above. I understand I may be charged a reasonable cost-based fee for copies of the records. Applicable postage fees may also apply. My request will be processed within 15-days of the practice's receipt of my completed request and records will be mailed to the above address, unless otherwise indicated. If the practice does not maintain my records, I will be informed where to direct my request, if known.

_____ _____
Signature of Patient or Patient's Personal Representative Date

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

OFFICE USE ONLY

MUST BE COMPLETED: Records request processed by: _____ (name of employee) on: _____ (date).

Complete one of the following:

1. Records were mailed on _____ (date) and by _____ (processing employee's name).
2. Records were picked-up on _____ (date) and by _____ (name). Photo-ID verified by: _____.
3. Records were reviewed in-person on _____ (date) and by _____ (name).
   Photo-ID verified by:_____. Review of records conducted in presence of _____ (name of employee).
4. Access to Medical Records was denied ❒ Reason for denial: _____ (**Contact Compliance Director**)

Notes: _____

Instructions for completing the
Request to Review and/or Obtain a Copy of Protected Health Information

Please complete this form if you wish to receive medical records for your or your minor child. Legibly print the requested information so we may accurately identify the patient. We do not fax records.

1. Check ✓ the box of the practice site where you are requesting to review and/or obtain a copy of your or your child's medical records.

   - Write in the patient's full name, including middle initial and any other names used.
   - Write in a contact phone number where we may contact you should we have questions about your request.
   - Write in the patient's date of birth.

2. If you are requesting records from **The Pediatric Lung Center & Allergy** or **Pediatric & Adolescent Sleep Center**, you have the choice of receiving your or your child's records in paper **or** USB flash drive (electronic) format. If you request records as a USB flash drive, please be advised that the device will not be password protected or encrypted. You will be responsible for the security of the device once it is in your possession. If you are requesting records from the **Pediatric Surgical Group**, **Pediatric Infectious Disease Group**, **Fairfax Neonatal Associate, or MCAP**, records are only offered as paper copies. Please speak with the Medical Records Representative if you have any questions.

NOTE: Medical records provided to you in paper or electronic format are your responsibility to secure from unauthorized access.

3. Check ✓ the box to indicate how you would like to receive the records and fill-in any requested information.

   - If you would like the records **mailed** to your current address, please provide your complete mailing address, including the 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. We will require you to show photo-identification before we release 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. We will require that an employee of the practice be present during your review of the records. Photo-identification is required before we allow you to review the records.

4. Select the types of medical records you are requesting. If a type of record you would like to request is not listed, provide a description of that record where it states, "Other".

   - Provide the Date(s) of Service or a date range for the requested records.

Sign your name on the "signature" line. Indicate the date you are signing the form. Print your name below the signature line. If you are not the patient, provide your relationship to the patient.

If you have questions about accessing patient medical records, please call the outpatient site where services were received. You may fax your completed request form to the site where services were rendered. If you have questions regarding patient billing records only, call Management Consultants for Affiliated Physicians, Inc. (MCAP) at (703) 289-1400 to speak with a billing representative.

Fairfax Neonatal Associates Phone: (703) 289-1400 Fax: (703) 289-1414	**The Pediatric Lung Center & Allergy** Phone: (703) 289-1410 Fax: (703) 289-1420
Pediatric Infectious Disease Group Phone: (703) 226-2280 Fax: (703) 752-1713	**Pediatric Surgical Group** Phone: (703) 560-2236 Fax: (703) 876-4960
Pediatric and Adolescent Sleep Center Fairfax Location - Phone: (703) 226-2290 Fax: (703) 226-2291 Purcellville Location - Phone: (540) 751-1955 Fax (540) 751-1954	**MCAP** Phone: (703) 289-1400 Fax: (703) 289-1414