FNA
Fairfax Neonatal Associates PC
a Neonatal & Pediatric Subspecialty Group

Fairfax Neonatal Associates
Pediatric Lung and Allergy Center (703) 289-1410
Pediatric Surgical Group (703) 560-2236
Pediatric and Adolescent Sleep Center (703) 226-2290

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

Patient Name: _____
Last First Middle Other Name

Contact Phone#: (_____)_____ **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 and Allergy Center (**PLAC**)	
❒ Pediatric Infectious Disease Group (**PIDG**	❒ Pediatric and Adolescent Sleep Center (**PASC**)	❒ Pediatric Surgical Group (**PSG**)

2. Select the format you would prefer: ☐ **Paper** ☐ **USB Flash Drive (for PLAC and PASC records 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** (requires photo-ID at the time of pick-up).

☐ **Fax to** _____ (**paper format only** - I understand that the information faxed poses a risk it could be accessed inappropriately by others if the fax machine is not securely located). **If you agree, initial here**: _____.

☐ **Email to** _____ (By providing my email address I elect to receive records in PDF format via encrypted email communication. If I choose to receive in an unencrypted manner, I understand there is a risk it could be accessed inappropriately.) **If you agree, initial here**: _____.

☐ **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 and the range of date(s) of service requested.

REQUIRED: Date(s) or date range of service you are requesting: ❒ Last visit note ❒ Last 3 visit notes ❒_____

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

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 30-days of the practice's receipt of my completed request. 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: _____ (employee name) on: _____ (date).
Complete one of the following:

1. Records were ❒ Mailed ❒ Emailed ❒ Faxed on _____ (date) and by _____(employee name).
2. Records were ❒ Picked-up ❒ Reviewed in-person on _____ (date) and by_____ (patient/personal presentative name).
   Photo-ID verified by:_____. Review of records conducted in presence of _____ (employee name).
3. Access to Medical Records was denied ❒ Reason for denial: _____ (**Contact Compliance Director**)

Notes: _____

Instructions for completing the
Request to Obtain and/or Review 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.

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 for questions or when the records are ready for pick up.
   - Write in the patient's date of birth.

2. If you are requesting records from **Pediatric Lung and Allergy Center** or **Pediatric and 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.

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 the records **emailed** or **faxed** to you, please provide your complete and accurate email or fax number. Please initial that you are aware and agree to accept the potential risk associated with receiving PHI by email or fax communication.

   - 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 Fairfax Neonatal Associates, P.C. Billing Office at (703) 289-1450 to speak with a billing representative.

Fairfax Neonatal Associates Phone: (703) 289-1400 Fax: (703) 289-1414	**Pediatric Lung and Allergy Center** Phone: (703) 289-1410 Pulmonology Fax: (855) 208-6095 Allergy Fax: (855) 208-6277
Pediatric Infectious Disease Group (practice closed in 09/2014) Phone: (703) 289-1400 Fax: (703) 289-1414	**Pediatric Surgical Group** Phone: (703) 560-2236 Fax: (855) 208-6018
Pediatric and Adolescent Sleep Center Fairfax Location - Phone: (703) 226-2290 Fax: (855) 208-6428	**Fairfax Neonatal Associates, PC Billing Office** Phone: (703) 289-1450 Fax: (703) 289-1414