Fairfax Pediatric Associates

13135 Lee Jackson Memorial Hwy, Suite 201 Fairfax, VA 22033 Ph:703-391-0900 Fax: 703-391-2919

REQUEST FOR ACCESS TO HEALTH INFORMATION
(records given directly to an emancipated minor or a minor's parent/guardian))

SECTION A: Patient to complete the following information.

DATE:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Patient Address:_____

Patient Telephone No_____

REQUEST:
I hereby request that FPA provide me with **(check all boxes that apply)**:

☒ **Access to**, or ☒ **My own copy** of the requested information checked below:
☒ **My medical record summary** to include Immunization Record, Growth Chart, and Summary Medical History
☒ **My complete medical record**. I understand this will incur the charges below.
☒ **My billing records.**
☒ Any other personally identifiable information used by FPA to make medical decisions about me. Please describe: _____
☒ I am interested in accessing or obtaining a copy of all requested information maintained by FPA.
☒ I am interested in accessing or obtaining a copy of the requested information relating to the following time period: _____ through _____

CHARGES

Complete Medical Record on CD	$5.00/quarter hour
CD Material cost	$1.00 per CD
Postage	_____
Paper Copy	$ 0.15 per page

# of CD's _____ # of Quarter hours _____

(# of pages) _____@ $.15 = $_____

+ Postage_____

Total charges:$_____
This charge may be paid by cash, personal check, and money order, VISA® or MasterCard®.

Signature of patient or legal representative: _____

Printed name of legal representative: _____

Relationship to patient: _____

SECTION B: FPA to complete this section.

Request for access or copy is ☒ Accepted ☒ Denied

If denied, check the following reason for denial:

- ☒ PHI is not part of the patient's designated record set
- ☒ Federal law forbids making the requested information available to the patient for inspection (e.g., CLIA or Privacy Act of 1974)
- ☒ The requested information is psychotherapy notes
- ☒ The requested information has been compiled for legal proceeding
- ☒ The requested information was obtained under promise of confidentiality and access would be reasonably likely to reveal the source of the information
- ☒ The requested information is temporarily unavailable because the individual is a research participant
- ☒ Licensed health care provider has determined that access to the requested information would result in physical harm to the individual or others
- ☒ Licensed health care provider has determined that the requested information identifies a third person who may be physically, emotionally, or psychologically harmed if access to the information is granted
- ☒ Licensed health care provider has determined that access to the requested information by the patient's legal representative could result in harm to the individual
- ☒ We are acting under the direction of a correctional institution and letting the inmate access or obtain a copy of the requested information would jeopardize the health, safety, security, custody, or rehabilitation of another person at the correctional institution
- ☒ The requested information is not maintained by our facility

RIGHT TO REVIEW:

You ☒ do ☒ do not have the right to a review of this denial.

Contact information _____
_____
_____

☒ You do have a right to file a complaint with our facility and may do so by contacting the Privacy Officer at (703) 391-0900. You also have the right to file a complaint with the secretary of the Department of Health and Human Services. Please see the enclosed information.

Staff Comments:_____

_____

_____

Signature of staff person: _____

Print name and title: _____