



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 USB	\$20.00 Search/
USB Material cost \$1.75	Handling Fee
Postage	_____
Paper Copy	\$ 0.15 per page
# of USB's _____	
(# 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: _____