Frederick Primary Care Associates, P.A.

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

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I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is $0.50 per page copied for the first 50 pages and $0.25 per page for every page over fifty plus any actual postage costs incurred. I also understand that my records will not be delivered to my authorized representative or me until these fees have been paid.

I also understand that if I wish to personally inspect my Protected Health Information at the Frederick Primary Care Associates office where the records are maintained, I will need to make an appointment to do so. Frederick Primary Care Associates will make an appointment for you to review your records within 30 days of the receipt of this request. A Frederick Primary Care Associates staff member will be present at all times while you review your medical records. Please indicate dates and times that you would be available to review your records during our normal operating hours of 9:00 AM to 5:00 PM Monday through Friday: _____

_____

_____

FPCA Office Location

☐ 56 Thomas Johnson Dr	☐ 63 Thomas Johnson Dr	☐ Ballenger Creek
☐ Brunswick/Jefferson	☐ Spring Ridge	☐ Walkersville
☐ Woodsboro	☐ FPCA Physical Therapy	

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient or Legal Guardian Phone Number

FOR INTERNAL USE ONLY: