

FAMILY PHYSICIANS OF O'FALLON  
ACCESS REQUEST FORM

<b>Patient's Name:</b>	_____	_____	_____
	Last	First	Middle
<b>Home Address:</b>	_____		
	_____		
<b>Home Phone:</b>	_____	<b>Date of Birth:</b>	_____

I am requesting the above records for the purpose of:

- Personal use
- Specialist visit
- Transfer of care
- Other \_\_\_\_\_

I hereby request that the Practice provide me with **[please check all boxes that apply]**

- My medical records (see fees on back)
- My billing records
- The attached FMLA, disability, accident or other **FORM** (see fees on back)
- Specific Information (Define) \_\_\_\_\_

Please check one of the following boxes:

- I am only interested in accessing or obtaining a copy of the Requested Information for the following time period (From)\_\_\_\_\_ (To) \_\_\_\_\_
- All available

I understand that any information provided to me pursuant to this request will not include psychotherapy notes, information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be required by applicable law.

I understand that the Practice may deny this request under limited circumstances permitted by federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the Practice who did not participate in the Practice's decision to deny my request.

