



# Pharmacy Form Request to Access Records

## What is the Purpose of this Request?

You have a right to request a copy of your protected health information contained in a designated record set and held by Wal-Mart, SAM'S Club, and Neighborhood Market Pharmacies, collectively "Wal-Mart". This request must be made in writing, and may be denied by Wal-Mart under certain circumstances. Your request will be acted upon within 30 days (60 days if the information is off site), unless we provide you with notification in writing that an extension of up to 30 days is needed.

## Section 1: Patient Information

Patient Name:		Date of Birth:	
Address:			
City:	State:	Zip:	Phone:

## Section 2: Information Requested

<p>a. I request copies of the following health information:</p> <p><input type="checkbox"/> Specific Prescription(s): _____</p> <p><input type="checkbox"/> Medical Expense Summary (List of all prescription expenses)</p> <p><input type="checkbox"/> Designated Record Set (Entire medical record maintained by the Pharmacy)</p>
<p>b. For the following dates of service: (indicate specific treatment dates or date ranges)</p>
<p>c. From the following facilities: (list Wal-Mart, SAM'S, or Neighbor Market, including city and/or state)</p>

## Section 3: Signature and Date

I understand that I am allowed to have access to these records and that the information will be provided to me in hardcopy form. If I am denied access/inspection to these records, I understand that I may appeal the denial.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Today's Date

If you have signed this form as a legally authorized representative of the Patient, please print your name and relationship to the Patient below.

\_\_\_\_\_  
Name of Personal Representative (please print)

\_\_\_\_\_  
Relationship to Patient (parent, legal guardian, etc.)

Please check (✓) this box if you would like to receive a copy of this form after you have signed it.

## For Office Use Only

Request Status: <input type="checkbox"/> Approved <input type="checkbox"/> Denied	_____	_____
	Date	RPh Initials