Pharmacy Form
Request to Amend / Correct Health Information

What is the Purpose of this Request?

You have a right to request that Wal-Mart, SAM'S Club, and Neighborhood Market Pharmacies (collectively "Pharmacy") amend your Health Information contained in a designated record set held by the Pharmacy. This must be requested in writing, and may be denied under certain circumstances. We will act upon your request within 60 days, 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: Amendment / Correction Requested

(a) Describe the Amendment or correction you would like made (be specific):

____

____

(b) Why is this amendment / correction appropriate or necessary:

____

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(c) Identify any other persons/groups you believe have received your health information that need to be notified of the amendment / correction you are requesting:

____

____

Section 3: Signature and Date

By Signing this form, I am requesting that the Pharmacy amend or correct my health information as stated above. If the Pharmacy agrees with my request, the Pharmacy may provide the amendment/correction to relevant third parties, including those identified in Section 2(c) above.

______________________________ ______________

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: ☐ Approved ☐ Denied

__________ __________

Date RPh Initials