Sid's Pharmacy

PART A

PATIENT REQUEST TO ACCESS PHI FORM

PATIENT FILLS OUT

Name: _____

Date of Request: _____

Date of Birth: _____

Method of Request: (circle one) Written / Verbal*

Description of Protected Health Information Requested:

_____

1. This request will terminate sixty (60) days after the date listed below or upon the occurrence of _____, whichever occurs first.

2. I understand that the Pharmacy may deny my request if it is permitted to do so by state and federal law.

3. I agree that the Pharmacy may provide a summary of the information requested instead of copies of the actual records. I agree to pay the Pharmacy all reasonable fees incurred in preparing the summary and providing it to me.

4. I request that the information is delivered to me in (circle one): printed copy / e-mail / other electronic format (specify): _____.

_____ _____

Patient (or Personal Representative*) Signature Date

_____

Printed Name

If signed by Personal Representative, state relationship to Patient: _____

(*) If the Patient requests protected health information verbally rather than in writing, the request will be documented in the Patient's medical record.

ORIGINAL: In Patient Documents (in patient Profile WinRx)
COPY: To Patient (or Personal Representative)