Request to Release, Access, or Inspect Protected Health Information (PHI)

Purpose: This request is used by a Patient, Patient's Personal Representative, or Authorized Person (as defined by the Ohio Revised Code §3701.74(11)) to authorize Discount Drug Mart (DDM) to release PHI to an individual or organization not otherwise authorized to receive it as required by the laws of the State of Ohio, the federal Health Insurance Portability and Accountability Act, and other federal laws.

Patient Information:

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

Scope of Release (check the appropriate option(s) and/or fill in the blank(s) desired):

I request the release of:

◯ Specific Prescription(s):_____ ◯ List of all prescriptions filled

For the following dates:

◯ All dates of service readily retrievable

◯ Only from and including _____ to _____

From the following DDM entities:

◯ All locations where services were provided

◯ Only the following DDM locations: _____.

To the following recipient(s):

◯ Held for the requestor at the following DDM location: _____ for up to 30 days.

◯ Mailed to the patient at the address on file.

◯ Mailed to the recipient named below:

Recipient Name:		Organization Name:	
Recipient Address:			
City:	State:	Zip Code:	Phone Number:

For the following purpose(s):

◯ Tax ◯ Continuing Care ◯ At the request of the individual ◯ Other _____

I hereby grant permission for Discount Drug Mart to release a copy of my PHI as requested above. I understand that PHI released by this request may contain information concerning treatment for a sexually transmitted disease, communicable disease, alcohol, drug abuse, a psychiatric condition, or HIV test results, an AIDS diagnosis, or AIDS-Related condition. This authorization is valid from the date of completion of this request for one year, and may be revoked by me in writing at any time, except to the extent that action has been taken in reliance. The revocation must be provided to privacyofficer@discount-drugmart.com or by calling 330-725-2340 x84480.

I understand that signing this request is voluntary and receipt of services from DDM is not conditional upon my request of this release. I understand that if I request the release of PHI to a recipient who is not legally required to keep it confidential, the information may be redisclosed and may no longer be protected by state and/or federal privacy laws.

_____ _____

Signature of Patient, Personal Representative, or Authorized Person — Today's Date

If a Personal Representative, please print your name and relation to the patient (Legal Guardian, Parent, etc…)

_____ _____

Printed Name of Personal Representative — Relation to Patient

INTERNAL USE BY PHARMACY

Verify person receiving PHI (*must be authorized)* by inspecting a valid form of identification:

Driver's License: Y / N Or other form of identification: Y / N List type of ID: _____

Name of employee performing verification: _____ Signed: _____ Date: _____