RIGHT TO ACCESS AND CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

POLICY: In the case of a verbal or written request for PHI (Protected Health Information) included in the Pharmacy's Medical Expense and Accounts Receivable Information, the Pharmacy will (at the discretion of the Pharmacist, Privacy officer, or person receiving a written or verbal request) release patient specific information limited to and as included in it's then current Medical Expense and/or Accounts Receivable Information directly to the patient or authorized agent of the patient after having the release herein previously completed.

PURPOSE: In any case where the requested information goes beyond the Pharmacy's then current Medical Expense and/or Accounts Receivable Information or a Pharmacy employee believes the patient's PHI is best protected by having the release herein completed prior to release of any PHI, this release serves as the documented request for the release of Protected Health Information (PHI) to the patient or authorized agent of the patient as designated below.

I am requesting the following PHI (check only those that apply):

- ❑ **PRESCRIPTION MEDICATION ACTIVITY INFORMATION (detailed report including copay information)**
- ❑ **MEDICAL EXPENSE SUMMARY (total expenditures by patient)**
- ❑ PRESCRIPTION EQUIPMENT or DEVICE ACTIVITY INFORMATION (contact corporate)
- ❑ PATIENT DEMOGRAPHIC INFORMATION (pharmacy or corporate)
- ❑ BOOKKEEPING / ACCOUNT RECEIVABLE ACTIVITY INFORMATION (corporate)
- ❑ CURRENT INSURANCE INFORMATION (FOR THE DATE OF REQUEST) (pharmacy or corporate)
- ❑ OTHER (SPECIFIC DETAIL REQUIRED)_____

I, _____ hereby authorize the release of my protected health information (PHI) to the

Print Name of Patient whose PHI is needed

following person or classes of persons:_____

Name(s) Printed

This form is valid for only the dates requested. The specific time period for which records are being requested *(no future dating allowed)* is _____to_____. I also certify that the records being requested are my own personal records.
DATE / MONTH / YEAR

Signature of Patient_____Date___/____/___ Date of Birth ___/___/___

Please check the manner in which you prefer to receive this information:

- ❑ Pick up at Pharmacy
- ❑ Mail
  Address:_____/_____/_____/_____
  Street City State Zip code

This disclosure is being made for the purpose(s) of:_____

_____

Routine requests processed at store level may typically be completed after 1 business day. *(ask pharmacy staff)* Depending on the type and format, your request for information may take up to 30 business days. The information may be obtained here at the pharmacy or mailed (note address above) to you at your request. This form must be completed in its entirety (no blank lines) and returned to begin processing information. Failure to return this form will result in your request not being processed. Thank you for your patience.

Signature of Person Receiving PHI: _____ Date: ____/____/_____
(must be authorized above)
Print Name of Person Receiving PHI: _____

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_____

V2-032015