Request for Restrictions

I request to: ☐ Add a Restriction ☐ Remove a Restriction Store/Club #_____

This form is used by you or your personal representative to request that Walmart and Sam's Club Pharmacies, Vision Centers/Opticals, or Walmart/Sam's Club Optometrists (collectively "Walmart") restrict uses and disclosures of your Protected Health Information ("PHI") maintained by Walmart. You may also use this form to remove a restriction you have already made on the use or disclosure of your PHI. In completing this form, you are requesting to restrict or remove the restriction on the use and disclosure of the PHI you have indicated below. Walmart is not required by law to agree to most requests for restrictions. If we agree to your request, we will be bound by your request. You will be notified in writing of the decision to accept or deny your restriction request. Until a decision is reached, your request will not be honored.

If you have paid for a treatment or service in cash, you have a right to restrict the disclosure of this treatment or service to your insurance health plan. You must list each prescription you wish to restrict, and your request will be effective for this store/club only. Walmart must agree to this requested restriction. However, Walmart reserves the right to disclose the PHI when required by law.

Section 1: Patient Information

Patient Name (last, first, middle initial):			Date of Birth (mm/dd/yyyy):
Address:			
City:	State:	Zip:	Phone:

Section 2: Requested Restriction

(a) Describe the restriction(s) you are requesting (be specific and attach additional pages if needed): (*Refer to (c) if you have paid for your treatment or service in cash and you are requesting a restriction to your insurance health plan.*)

(b) Why is adding/removing this restriction appropriate or necessary?

(c) If you have paid for the treatment or service in cash and your restriction request is to an insurance health plan, list each prescription you wish to restrict or remove from a restriction: (Fill out a new request for each store/club in which you have filled these prescriptions.)

Section 3: Signature and Date

a) I understand that if this restriction request is granted, it does not apply to PHI that has already been used or released prior to the receipt of this request.
b) I understand that if my restriction request is granted, it will continue until the agreement is terminated. If I wish to terminate this restriction request, I must do so in writing. If Walmart terminates this restriction request, the termination will be effective only with respect to health information created or received by Walmart after Walmart notifies me of the termination.
c) I understand that Walmart reserves the right to disclose the PHI when required by law.
d) I understand that my restriction request applies to this store/club only.
e) I understand that if I paid for an item or service in cash and my restriction request is to my insurance health plan, I must list each prescription that I wish to restrict/remove from restriction.

Signature of Patient or Personal Representative _____ 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.) _____

ATTENTION ASSOCIATES: For Cash Pay Restrictions, do not fax this form to the Home Office. Complete the box below titled 'Cash Pay Restriction' and maintain a copy for your records. For all other restrictions, fax this form to Digital Citizenship, HIPAA Privacy at (866) 340-0602.

Store/Club Use Only
Cash Pay Restrictions

☐ Approved

Date _____ RPH/RDO/ Optician/AOD Initials _____

Store/Club Number:

For Home Office Use Only

Request Status: ☐ Approved ☐ Denied

Store/ Club Number: _____ Date _____

Reason if denied:

See POM/VCOG 1616