Accounting of Disclosures Request

I request an Accounting of Disclosures for:

☐ Pharmacy ☐ Vision Center/Optical ☐ Walmart/Sam's Club Optometrist

What is the Purpose of this Request?
This request provides you with an accounting of disclosures of your Protected Health Information ("PHI") made by a Walmart or Sam's Club Pharmacy, Vision Center/Optical, or Optometrist (collectively "Walmart") in the six years prior to the date of your request (or shorter timeframe based on your selection). The list will not include certain disclosures, including, but not limited to, those disclosures Walmart made for your treatment, payment, and/or health care operations purposes, those that are a result of another permissible use or disclosure, those made under an authorization provided by you, those made directly to you or to those who were involved in your care (e.g., family or friends), or for disaster relief purposes. The list also may not include certain disclosures Walmart made for national security purposes or to law enforcement personnel. You must submit a separate request at each Pharmacy or Vision Center/Optical location from which you would like an accounting of disclosures.

Section 1: Patient Information

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

Section 2: Request Information

a. I would like an accounting of disclosures for the following time period (not to exceed 6 years):

b. From the following facility: (list Walmart and Sam's Club location, including city and state, store/club number, as well as whether the request pertains to Pharmacy, Vision Center/Optical, or Optometrist)

Section 3: Signature and Date

_____ _____
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.)

☐ Check this box if the patient is deceased.

For Store/Club Use Only

Send completed form to Digital Citizenship HIPAA Privacy. See POM/VCOG 1613.

Store/Club Number: _____ RPh/RDO/Optician/AOD Initials: _____

Request Status: ☐ Sent to *Digital Citizenship HIPAA Privacy*

Date: _____