

Accounting of Disclosures Request



I request an Accounting of Disclosures for: Pharmacy Information Vision Center/Optical Information
 Care Clinic

What is the Purpose of this Request?

This request provides you with an accounting of disclosures of your Protected Health Information ("PHI") made by Walmart and Sam's Club Pharmacies, Vision Centers/Opticals or Care Clinics (collectively "Walmart") in the six years prior to the date of your request. The list will not include certain disclosures, including, but not limited to, those Walmart made for your treatment, payment and 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 disclosures Walmart made for national security purposes or to law enforcement personnel. You must submit a separate request at each Pharmacy, Vision Center/Optical or Care Clinic 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:
b. From the following facility: (list Walmart and Sam's Club locations, including city and state, store/club number and whether the request pertains to the Pharmacy, Vision Center/Optical or Care Clinic)

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.)
<input type="checkbox"/> Check this box if the patient is deceased.	

For Office Use Only

Store/Club Number: _____
Request Status: <input type="checkbox"/> Approved <input type="checkbox"/> Denied _____ Date RPh/ RDO/ NP Optician Initials
Reason if denied: _____
Fax this form to the Legal Department at (479) 204-9696.

