Request to Amend / Correct Protected Health Information

What is the Purpose of this Request?
You have a right to request that Walmart and Sam's Club Pharmacies, Vision Centers/Optical and Care Clinics (collectively "Walmart") amend your Protected Health Information ("PHI") maintained by Walmart. Your request to amend your PHI may be denied under certain circumstances. Walmart will act upon your request within 60 days, unless Walmart provides you with notification in writing that an extension of up to 30 days is needed.

Section 1: Store/Club Information ☐ Pharmacy ☐ Vision Center/Optical ☐ Care Clinics

Store/Club Number:	Store/Club Location:

Section 2: Patient Information

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

Section 3: Amendment / Correction Request

(a) Describe the amendment or correction you would like made (be specific):

(b) Why is this amendment / correction appropriate or necessary:

(c) Identify any other persons/groups you believe have received your health information that need to be notified of the amendment / correction you are requesting:

Section 4: Signature and Date

By signing below, I am requesting Walmart to correct or amend my health information as stated above. If Walmart agrees with my request, the Pharmacy, Vision Center/Optical, or Care Clinic may provide the amendment/correction to relevant third parties, including those identified in Section 2(c) above. If my request is denied, I understand I will have an opportunity to submit a statement of disagreement to the denial, which will be included in my record.

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.) _____

For Office Use Only

Request Status: ☐ Approved ☐ Denied _____ Date _____ RPh/ NP/RDO/ Optician Initials

Reason if denied: _____

Fax this form to the Legal Department at (479) 204-9696.