Request for Confidential (Alternative) Communications

I request a Confidential (Alternative) Communication for: ☐ Pharmacy ☐ Vision Center/Optical ☐ Care Clinic

What is the Purpose of this Request?

This form is used by your or your personal representative to request that communications of a Patient's Protected Health Information ("PHI") be received from a Walmart and Sam's Club Pharmacies, Vision Centers/Opticals or Care Clinics (collectively "Walmart") location by alternative means or at alternative locations. Your request may be denied if it cannot be accommodated reasonably. You must submit a separate request at each Pharmacy, Vision Center/Optical or Care Clinic location from which you would like to request an alternative means of communication.

Section 1: Patient Information

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

Section 2: Communication Method

Initial the line below that describes how you would like to receive communications of PHI from the Pharmacy, Vision Center/Optical or Care Clinic:

(a) ____Telephone
The phone number(s) where I may be contacted: _____

_____

(b) ____Mail
The alternate address where I may be contacted:
Address:_____
City:_____State:_____Zip:_____

(c) ____Encrypted Email – Not available in all locations (Emails will be sent via Securemail. You will be required to create a username and login to access the file.)
The email address where I may be contacted: _____

(d) ____Unencrypted Email – Not available in all locations
The email address where I may be contacted: _____
☐ By checking this box, I indicate that I prefer to receive unencrypted email, which may not be secure and may place my information at risk.

(d) ____The Pharmacy, Vision Center/Optical or Care Clinic may contact me by the following method (be specific):

Section 3: Signature

Please note that if you request confidential communication, the Pharmacy, Vision Center/Optical or Care Clinic will send all correspondence to you to the address you provide and/or will call you at the alternative phone number you provide. The Pharmacy, Vision Center/Optical or Care Clinic will continue to contact you as directed by this request until advised in writing that you would like to use another method of communication. If you would like to change this method of communication, you must fill out a new form with your new contact information.

_____ _____
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

Store/Club No: _____

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

Reason if denied: _____
_____