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 you or your personal representative to request that communications of a Patient's Protected Health Information ("PHI") from a Walmart and Sam's Club Pharmacy, Vision Center/Optical or Care Clinic (collectively "Walmart") location be sent by alternative means or to alternative locations. Your request may be denied if it cannot be reasonably accommodated. 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 – Must be approved by Home Office (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 – Must be approved by Home Office
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 using the address you provide and/or will contact you at the alternative phone number or email address 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: _____ (For Email Requests: Send to HIPAA Compliance for review. See POM/VCOG/COM 1615)
Request Status: ☐ Approved ☐ Denied _____Date_____ RPh/ RDO/NP/Optician Initials

Reason if denied: _____