

Accounting of Disclosures Request



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

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 or Vision Center/Optical (collectively “Walmart”) in the six years prior to the date of your request (or shorter timeline based on your selection). 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 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 locations, including city and state, store/club number and whether the request pertains to the Pharmacy or Vision Center/Optical)

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 Store/Club Use Only

<i>Vision Center/Optical: Send completed form to Digital Citizenship HIPAA Privacy. See POM/VCOG 1613.</i>	
<i>Pharmacy: Fulfill at store level after verifying content, per POM/VCOG 1613, or send completed form to Digital Citizenship HIPAA Privacy.</i>	
Store/Club Number: _____	RPh/RDO/Optician Initials: _____
Request Status: <input type="checkbox"/> Fulfilled <input type="checkbox"/> Sent to <i>Digital Citizenship HIPAA Privacy</i>	
Date: _____	