Request to Access Records Cover Sheet

Request for: ☐ Pharmacy Information ☐ Vision Center/Optical Information ☐ Care Clinic

What is the purpose of the Request?

This form allows you to request your Protected Health Information ("PHI"). You and your personal representative have a right to request a copy of your PHI maintained by Walmart and Sam's Club Pharmacies, Vision Centers/Opticals or Care Clinics (collectively "Walmart"). Legal Authorization for the request is required and must be faxed to Walmart Legal at 479-204-9696 along with this cover sheet. The request may be denied by Walmart under certain circumstances. Your request will be acted upon within 30 days unless Walmart provides notification in writing that an extension of up to 30 days is needed.

Section 1: Patient Information

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

Section 2: Information Requested

(a) I request copies of the following Protected Health Information (PHI):

☐ Medical Expense Summary (list of all prescription expenses)
☐ Designated Record Set (entire medical record maintained by the Pharmacy or Care Clinic)
☐ Dispensing Records (entire medical record maintained by the Vision Center/Optical)

(b) For the following dates of service: (indicate specific treatment dates or date ranges)

____

____

(c) I request copies in the following format:

☐Printed copy – store pick-up
☐Printed copy. Mail to:____
☐Electronic copy. Provide email address: ____

A login code and password will be sent to the email address you provide. These will allow you to access your PHI electronically through a secure website.

Section 3: Signature and Date

I understand that I am allowed to have access to these records and that the information will be provided to me in either hardcopy or electronic form. If I am denied access/inspection to these records, I understand that I may appeal the denial to the Walmart HIPAA Compliance Office at 702 SW 8th Street, Mailstop 0230, Bentonville, AR 72716-0230.

____ ____________________

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.)

☐Check this box if the patient is deceased.

For Walmart/Sam's Club Use Only

Store/Club Number:______________

Request Status: ☐ Approved ☐ Denied ___________ ____________

Date RPh/RDO/ Optician Initials

Reason if denied:____

List all locations where the patient requests access (store/club number):

____

Associate: Complete this form if someone other than the patient or a minor patient's parent requests records.

Associate name:____

Legal document provided:___________________________________

(e.g. power of attorney or guardianship papers)

Associate signature: ______________________________________

Fax a copy of the document and this form to Legal at 479-204-9696.

Patient Privacy. Our Priority!