

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

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 or Vision Center/Optical (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 or Vision Center/Optical 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 or Vision Center/Optical:

(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.

(e) **The Pharmacy or Vision Center/Optical may contact me by the following method (be specific):**

Section 3: Signature

Please note that if you request confidential communication, the Pharmacy or Vision Center/Optical 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 or Vision Center/Optical 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 Store/Club Use Only

Store/Club No: _____	(For Email Requests: Send to Digital Citizenship HIPAA Privacy for review. See POM/COG 1615)
Request Status: <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Date: _____ RPh/ RDO/Optician Initials: _____
Reason if denied: _____	