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.

Authorization to Release Protected Health Information
(Authorized Representative)

I authorize the release of ☐ Pharmacy Information ☐ Vision Center/Optical ☐ Care Clinic information from the following facility: (include city and state):

_____

What is the Purpose of this Request?
This request allows you to authorize others (e.g. family, friends) to access your Protected Health Information ("PHI"). You can authorize the release of your PHI maintained by Walmart and Sam's Club Pharmacies, Vision Centers/Opticals or Care Clinics (collectively "Walmart"). This Authorization will only apply to the health care service indicated above. You must fill out an Authorization for each Pharmacy, Vision Center/Optical or Care Clinic location from which you wish to release your PHI. If information from multiple stores is requested, then only the previous 2 years of records may be provided at store level. Vision Center/Optical and Care Clinic information can only be provided for the location where service was provided.

Section 1: Patient Information

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

Section 2: Requestor

Individual or Entity:		Person Receiving Information:	
Address:			
City:	State:	Zip Code:	Phone/Fax Number:

Section 3: Information to be Released (Check all that apply)

I authorize Walmart to release the following Protected Health Information (PHI):
☐ Medical Expense Summary (list of all prescriptions with expense information)
☐ Designated Record Set (entire medical record maintained by the Pharmacy or Care Clinic)
☐ Dispensing Records (entire record maintained by the Vision Center or Optical)
☐ Other (please describe):
For the following dates of service:
☐ All dates of service **or** From _____ to _____

Section 4: Expiration Date of Authorization

This authorization will remain in effect ☐ Until the following date: _____	☐ Until one year from the date of my signature below.

Section 5: Understandings (you must check all of the following)

☐ I understand that signing this authorization is voluntary. Walmart will not deny Pharmacy, Vision Center/Optical or Care Clinic services to me if I refuse to sign this authorization.

☐ I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be re-disclosed and my no longer be protected by federal or state privacy laws.

☐ I have the right to revoke this authorization at any time by completing a "Revocation of Authorization to Release Protected Health Information" form. The revocation will not apply if (i) Walmart released PHI prior to receiving the revocation; or (ii) this authorization was obtained as a condition to the patient obtaining insurance

☐ I understand by signing below I authorize the release of records that may include: HIV/AIDS related information; mental health information; drug/alcohol diagnosis and treatment information; pregnancy and family planning information; sexually transmitted disease information

Section 6: Signature and Date

_____	_____	_____
Name of Patient or Personal Representative (please print)	Signature of Patient or Personal Representative	Date

If you have signed this form as a legally authorized representative of the patient, please identify your relationship to the patient below. (parent, guardian, etc. _____

For Office Use Only

Store/Club Number:_____
Please initial to verify that you called the Patient who confirmed valid authorization: _____