Walgreens Custodian of Records, 1901 East Voorhees Street, MS 735, Danville, Illinois 61834
Fax: (217) 554-8955 Phone: (217) 554-8949 Email: myrecords@walgreens.com

REQUEST TO ACCESS, INSPECT, OR OBTAIN PROTECTED HEALTH INFORMATION

Request:

I request to review health information held about me in the Walgreens "designated record set" in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that Walgreens has 30 days to respond to this request, Walgreens may extend this 30-day response period for another 30 days, and in certain circumstances Walgreens may deny my request.

Information:

Patient First Name: _____ Patient Last Name: _____ Date of Birth: _____
Other Possible Names: (maiden, alias, if applicable): _____
Street Address: _____
City, State, Zip: _____
Telephone Number: _____ E-mail Address: _____
Previous Addresses: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

Please indicate the timeframe you are requesting records for. Dates of Service from: _____ to: _____

- ☐ Entire Prescription Record
- ☐ Immunization Records
- ☐ Other: _____
- ☐ COVID 19 Test Results
- ☐ Buyout Records (please provide pharmacy name) _____

*Please note: If you are a Walgreens Specialty patient, please select "Other" and write "specialty" in the line above.

Complete this section to direct your health information to the third party listed below; leave it blank if the records should be sent directly to you.

Third Party Recipient: _____ ___
Street Address: _____
City, State, Zip: _____
Telephone Number: _____ Fax Number: _____ E-mail Address: _____

METHOD FOR RECEIVING YOUR DISCLOSURE (Check only one box below)

- ☐ Mail
- ☐ Fax
- ☐ Email (Encrypted) In an effort to protect your health information, our standard practice is to encrypt our email.
- ☐ Email (Unencrypted) Signature Required. By signing you acknowledge that you understand an unencrypted email exposes your personal and health information to additional security risks. **SUGGESTED FOR HIGH SECURITY FIREWALLS (i.e. military)** Signature: _____

Signature:

Signature: _____ Date: _____
***Please note: typed signatures are not accepted.**

If you are signing this form as the legal representative of the individual named above and you are not the parent of the minor child listed, you must explain authority below and provide documentation proving your legal authority (such as a Power of Attorney that specifically authorizes access to medical information).

_____

[Revised: 03/11/2026]