Walgreens Privacy Office, 108 Wilmot Road, MS 3213, Deerfield, Illinois 60015
Phone:(847) 236-6518 Fax:(847) 236-0862

REQUEST RESTRICTIONS ON PHI USE AND DISCLOSURE

Acknowledgement

I understand that Walgreens may use and disclose protected health information ("PHI") about me without my written authorization for purposes of treatment, payment and health care operations. I am requesting that Walgreens restrict the use and disclosure of PHI for purposes of treatment, payment and health care operations about me as described below.

I understand that Walgreens is not required to agree to my requested restriction(s), except under limited circumstances when a restriction is related to a disclosure to a health plan and the health information relates to a service for which I have paid Walgreens out-of-pocket in full (a "Mandatory Restriction"). I understand that if Walgreens agrees to abide by my restriction(s), Walgreens may still use and disclose my information for (1) emergency treatment; (2) when I request to access my information; (3) when I request an accounting of disclosures of my information; and (4) for uses/disclosures unrelated to treatment, payment or health care operations for which consent, authorization, or an opportunity to agree or object is not required. I also understand that, except for Mandatory Restrictions, if Walgreens agrees to this restriction, either Walgreens or I may terminate this restriction at any time. Only I can terminate a Mandatory Restriction. The termination of the restriction is only effective for future uses and disclosures.

Patient Information

Patient Name: _____
Date of Birth: _____
Street Address: _____
City, State, Zip _____

Telephone Number: _____ E-mail Address: _____

Request for Restriction

Please complete all of the following questions. If the question is not applicable, mark N/A on the answer line.

I request the following information be restricted [*description of information*]:

_____

I request that use and disclosure of the above described information be restricted in the following manner [*description of restriction*]:

_____

I request that my PHI not be disclosed to the following individuals or entities [*list individuals or entities*]:

_____

Signature

I understand that if a restriction is not specifically listed above and agreed to in writing by Walgreens, it will not be effective.

Signature: _____ Date: _____

If signed by the Patient's personal representative, explain authority to act on behalf of the Patient:

Note: If you are signing this form as the legal representative of the Patient listed above, and are other than the parent of the minor child whose information is listed above, you will also submit an explanation below and documentation that establishes yourself as the legal representative of Patient. For example, a copy of a Power of Attorney that includes provisions to obtain medical information, etc.

_____

_____

Mail this completed and signed form to: Walgreens Privacy Office, 108 Wilmot Road, MS 3213, Deerfield, Illinois 60015; Phone: (847) 236-6518; Fax: (847) 236-0862.