Walgreens healthcare clinic

PLEASE MAIL OR FAX COMPLETED FORM TO: **Take Care Health Services Attn: PSC – ROI Department**
P.O. Box 691569, Orlando FL 32819 Phone: 855-925-4733 Fax: 888-297-8357

REQUEST TO ACCESS, INSPECT, OR OBTAIN PROTECTED HEALTH INFORMATION

Request:

I request to review health information held about me in the Walgreens Healthcare Clinics "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 Name: _____
Date of Birth: _____
Street Address: _____
City, State, Zip _____

Telephone Number: ( ) _____ E-mail Address: _____

Standard requests for records contain a fifteen (15) month time period. If your request for records is in excess of fifteen (15) months, please indicate the time frame below. Records are retained in accordance with State Board of Pharmacy, DEA, and other relevant laws and vary from state to state.

From: _____ To: _____

I further request that my health information is directed to the third party at the address designated below.

Third Party Recipient : _____
Relationship: _____
Street Address: _____
City, State, Zip _____

Telephone Number: ( ) _____ E-mail Address: _____

Agreement:

I agree that Walgreens may provide a summary of health information instead of allowing me to review the information (check response below):

☐ Yes ☐ No Fee for Summary: _____

I agree to pay any fees for copying or summarizing my health information. Fees will be reasonable and cost-based, and include only the cost of copying, postage, and preparation of a summary (if I agree to a summary).

I understand that this request does not apply to certain health information, including: (1) information that is not held in the designated record set; (2) information compiled in reasonable anticipation of or for litigation; and (3) other information not subject to the right to access information under HIPAA.

Signature:

Signature: _____ Date: _____

PLEASE MAIL OR FAX COMPLETED FORM TO**: Take Care Health Services Attn: PSC – ROI Department**
P.O. Box 691569, Orlando FL 32819 Phone: 855-925-4733 Fax: 888-297-8357

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 individual listed above, and are other than the parent of the minor child whose information is listed above, you must also submit documentation that establishes yourself as the legal representative. For example, a copy of a Power of Attorney that includes provisions to obtain medical information, etc.

Method for receiving your health information: (check only one box below)

☐ Paper

☐ 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 unencryped email exposes your personal and health information to additional security risks. Signature_____

If you require your health information in a format other than paper or email, please contact us at the number listed above. We may be able to accommodate your request at an additional charge.

Records from other Walgreens entities:

Please contact us if you need to receive records from other Walgreens entities.