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

PATIENT USE ONLY

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 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.

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. Records are retained in accordance with State Board of Pharmacy, DEA, and other relevant laws and vary from state to state.

Patient Name(s): _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (____) _____ Email Address: _____

Previous Addresses: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

Please indicate the time period you are requesting records for. Dates of Service From: _____ To: _____

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

*Please note: If you are a Walgreens Specialty patient, please indicate this in the other box.

METHOD FOR RECEIVING YOUR DISCLOSURE (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) **Physical 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 (ex: military)** Signature: _____

Physical 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 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.