

# Request for Access to or Copies of Protected Health Information

## American Discount Pharmacy

Note: This information may not be used for the release of health information for marketing purposes or for the release of psychotherapy notes.

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

I request that the Pharmacy provide me with copies of my protected health information as requested below:

**Summary** (for tax or insurance purposes)

Number of copies requested: \_\_\_\_\_

For the following dates: \_\_\_\_\_ through \_\_\_\_\_

**Detailed** (hard copies of all prescription records)

Number of copies requested: \_\_\_\_\_

For the following dates: \_\_\_\_\_ through \_\_\_\_\_

I understand that the Pharmacy may charge a fee for the costs of copying, mailing, or other supplies associated with my request.

**How would you like to receive this information?**

U.S. Mail                       Pick up at the Pharmacy

Facsimile – Fax # \_\_\_\_\_

Signature of Patient or Patient's Authorized Representative

Date

\_\_\_\_\_

\_\_\_\_\_

Print Name of Patient's Representative (if applicable)

Relationship to Patient

\_\_\_\_\_

\_\_\_\_\_