RIGHT TO ACCESS AND CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

POLICY: In the case of a verbal or written request for PHI included in the Pharmacy's Medical Expense and Accounts Receivable Information, the Pharmacy may (at the discretion of the Pharmacist, Privacy officer, bookkeeper or person receiving a written or verbal request) release patient specific information limited to and as included in it's then current Medical Expense and/or Accounts Receivable Information directly to the patient or authorized agent of the patient without having the release herein previously completed.

PURPOSE: In any case where the requested information goes beyond the Pharmacy's then current Medical Expense and/or Accounts Receivable Information or a Pharmacy employee believes the patient's PHI is best protected by having the release herein completed prior to release of any PHI, this release serves as the documented request for the release of Protected Health Information (PHI) to the patient or authorized agent of the patient as designated below.

I, _____ am requesting Millers of Wyckoff, Inc. provide me
Print Name of Person Requesting Information

a copy of PHI for
_____/_____/_____
Print Name For Whom PHI is Needed **&** **Date of Birth**

I am requesting the following PHI (check only those that apply):

- ❑ PRESCRIPTION MEDICATION ACTIVITY INFORMATION
- ❑ PRESCRIPTION EQUIPMENT or DEVICE ACTIVITY INFORMATION
- ❑ PATIENT DEMOGRAPHIC INFORMATION
- ❑ BOOKKEEPING / ACCOUNTING ACTIVITY INFORMATION
- ❑ CURRENT INSURANCE INFORMATION (FOR THE DATE OF REQUEST)
- ❑ OTHER (SPECIFIC DETAIL REQUIRED)_____

_____
_____

My relationship with whom the PHI is being requested is _____. A unique copy of this
Relationship
release must be completed for any given 12 month period. The specific time period for which records are being

requested (no future dating allowed) is_____to_____.
Time **Period**
This disclosure is being made for the purpose(s)
of:_____

_____

I certify the records being requested are my own personal records or I have the patient's authorization to request these records. I certify the records obtained are done so in good moral character and without malicious intent.

Your request for information will be completed within 30 business days. The information may be obtained here at the pharmacy or mailed (note address below) to you at your request. This form must be completed in it's entirety (no blank lines) and returned to begin processing information. Failure to return this form will result in your request not being processed. Thank you for your patience.

Signature: _____ Date: _____

Print Name: _____ Date of Birth of Signer_____

Mailing Address (Must match requesting person above): _____
_____

Contact Phone Number:_____

Revised 03/12/03 dmm