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

Request:

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 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: _____

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

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

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 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.

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) 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: _____

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

Signature:

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.

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