HIPAA PHI Access Request Form

The Health Insurance Portability and Accountability Act permits me to obtain copies of my Protected Health Information. I understand that I can only request access to my own records or those of my minor children or dependents. I request that Wegmans Pharmacy provide me my individually identifiable health information as indicated below. This request includes all of my individually identifiable health information that Wegmans Pharmacy maintains, creates, or otherwise obtains for purposes of filling my prescriptions or providing me with Pharmacy services. This information includes my name and address, the names of and contact information for my physicians, my medical conditions, and other prescription information.

- **If this request is for yourself:**
  - Please complete this form and mail it with a photocopy of your government issued ID and:
    - A utility bill in your name that reflects the same address shown on your ID, OR
    - This form notarized by a licensed Notary Public

- **If this request is for a deceased person please mail copies of available documentation including:**
  - Death Certificate OR
  - Executor Paperwork

- **If this request is for a minor child (under age 18) or dependent with a different last name please complete the following:**

  I am the legally appointed guardian or parent of a child with a different last name. I hereby declare that, as such, I am entitled to obtain any and all information requested regarding pharmacy records and prescription information for my minor child or dependent.

  Name of Minor Child or Dependent:_____

  Address: _____

  Date of Birth: _____

  Name of legal guardian:_____

Mail this form to:

Wegmans Chief Privacy Officer

P.O. Box 30844

Rochester NY 14603-0844

For questions or clarifications, please contact Wegmans Legal Department at (585)464-4660

Part One: Patient Information (for whom the PHI is being requested)

First Name **MI** **Last Name** **Suffix** **Date of Birth (MM/DD/YYYY)**

Primary Address

City **State** **Zip Code**

Phone Number

Time period of this request:

From (earliest date): ___________________________ To: (most recent date):_____________________________

☐ **If you would like paper copies check here**

If you would like electronic copies of prescription information that we filled for you during the time period you specified above, check the following as applicable:

☐ **Include Medical Expense Statement Summary**

☐ **Include scanned images for all medications**

☐ **Include scanned images for the following medications:**

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Format of electronic health information to be provided:
For security purposes, we will e-mail your electronic health information in encrypted Portable Document Format ("PDF") format.

Transmission of electronic health information to be provided by e-mail to the following e-mail address:

E-mail Address

NOTE: We will e-mail your electronic health information to you in encrypted PDF format. However, you assume all risks should the transmission be hacked or otherwise accessed by an unauthorized person.

Part Two: Transmission to another person

If you wish to have the electronic health information that you have requested above e-mailed to someone other than yourself, complete the following:

☐ I wish to have the electronic health information that I have requested above e-mailed directly to the following person rather than to me:

First Name **Last Name** **Suffix**

Address

City **State** **Zip Code**

E-mail Address

Phone Number

I understand that if my electronic health information includes any HIV/AIDS information, Mental Health information, and/or Alcohol and Substance Abuse information, this information will be transmitted as part of this request.

NOTE: We will e-mail your electronic health information in encrypted PDF format. However, you assume all risks should the transmission be hacked or otherwise accessed by an unauthorized person.

I attest that the above information is accurate and complete, and that Wegmans Pharmacy may rely on it to provide these services.

Customer Signature _____ **Date** _____

If a personal representative is signing for the customer, please indicate your relationship to the patient:

_____

This Section for Notary Use Only (to be used only if a utility bill cannot be provided)

On this _____day of _____, 20___, before me, a Notary Public in and for the State of _____, personally appeared_____
personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this instrument, and s/he executed this document in my presence.

Signed in: County of: _____
State of _____

Notary:_____

Notary Stamp would go here

OR

Notary Seal would go here