

MCGLYNN PHARMACY, INC
RIGHT TO ACCESS AND CONSENT FOR RELEASE OF
PROTECTED HEALTH INFORMATION (PHI)

POLICY: After the completion of the Right of Access and Consent Form the following checked information will be released to the patient or authorized agent.

PURPOSE: 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. Due to new HIPAA laws this form must be signed by each individual. Parents can sign for their children under the age of 18. Each spouse must sign their own form.

I, _____ am requesting McGlynn Pharmacy, 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: _____ Time: _____

Print Name: _____ Date of Birth of Signer _____

Mailing Address (Must match requesting person above): _____

Contact Phone Number: _____

For Office Use Only:
RIGHT TO ACCESS

CIRCLE ONE: WILL PICK UP MAIL PICKED UP

CLERK'S INITIALS _____