Request to Access Records

Request for: ☐ Pharmacy Record ☐ Vision Center/Optical Record ☐ Walmart/Sam's Optometrist Record ☐ Wellness App Record

What is the Purpose of the Request?

This form allows you to request your Protected Health Information ("PHI") that is maintained by the Walmart health service provider indicated above. You and your personal representative have a right to request a copy of your PHI maintained by a Walmart or Sam's Club health services provider (collectively "Walmart"). The request may be denied by Walmart under certain circumstances. Your request will be acted upon within 30 days unless Walmart provides notification in writing that an extension of up to 30 days is needed. This completed form and any necessary legal documentation can be turned into your local Walmart or Sam's Club health service provider or faxed to 479-204-9696.

What is Your Relationship to the Patient? ☐ Self ☐ Parent of Minor Patient ☐ Other/ Personal Representative*

*If you are requesting a copy of a patient's PHI and you are not the patient or a parent of a minor patient, then you must attach to this form one of the following documents: (1) a valid "Authorization to Release PHI" form completed and signed by the patient, or (2) a document that verifies your authority to access the patient's records as the patient's Personal Representative (e.g., letter or order of guardianship, power of attorney).

Section 1: Patient Information ☐Check this box if the patient is deceased.

*Required Fields: Patient's Full Name, Date of Birth, and Address

Patient Name (last, first, middle initial):			Date of Birth (mm/dd/yyyy):
Address:			Alternate Name:
City:	State:	Zip:	Phone:

Section 2: Information Requested

(a) I request copies of the following Protected Health Information (PHI):

☐ Medical Expense Summary (list of all expenses)

☐ Designated Record Set (entire medical record maintained by Pharmacy or Walmart/Sam's Optometrist)

To maintain optimal resolution, optical images must be delivered electronically. Please provide an email address in section (d) below to receive images.

☐ Dispensing Records (entire medical record maintained by Vision Center/Optical)

☐ Health Management Data from Wellness App

Provide email address associated with Wellness App account:_____

☐ Other (please describe) _____

(b) List states where services were provided:

_____

(c) For the following dates of service: (indicate specific treatment dates or date ranges)

_____

(d) I request copies in the following format:

☐Printed copy – store pick-up

☐Printed copy. Mail to:_____

☐Electronic copy. Provide email address: _____

A login code and password will be sent to the email address you provide. These will allow you to access your PHI electronically through a secure website.

Section 3: Signature and Date

I understand that I am allowed to have access to these records and that the information will be provided to me in either hardcopy or electronic form. If I am denied access/inspection to these records, I understand that I may appeal the denial to the Walmart HIPAA Privacy Office at 2608 SE J Street, Suite 8, Mailstop 0230, Bentonville, AR 72716-0230.

_____ _____

Signature of Patient or Personal Representative — Date

If you have signed this form as a legally authorized representative of the Patient, please print your name and relationship to the Patient below.

_____ _____

Name of Personal Representative (please print) — Relationship to Patient (parent, legal guardian, etc.)

For Store/Club Use Only

Store/Club Number: _____

Request Status: ☐ Approved ☐ Denied _____ _____

Date RPh/RDO/AOD Initials

Reason if denied:_____

Associate: Complete this form if someone other than the patient or a minor patient's parent requests records.

Associate name:_____

Legal document provided:_____

(e.g., power of attorney or guardianship papers)

Associate signature: _____

Fax a copy of the document and this form to Legal at 479-204-9696.