

Accounting of Disclosures Request

I request an Accounting of Disclosures for: Pharmacy Vision Center/Optical
 Walmart/Sam's Club Optometrist

What is the Purpose of this Request?

This request provides you with an accounting of disclosures of your Protected Health Information ("PHI") made by a Walmart or Sam's Club Pharmacy, Vision Center/Optical, or Optometrist (collectively "Walmart") in the six years prior to the date of your request (or shorter timeframe based on your selection). Please note the following:

- The list **will not include** certain disclosures, including, but not limited to, those disclosures Walmart made for your treatment, payment, and/or health care operations purposes, those that are a result of another permissible use or disclosure, those made under an authorization provided by you, those made directly to you or to those who were involved in your care (e.g., family or friends), or for disaster relief purposes.
- The list also may not include certain disclosures Walmart made for national security purposes or to law enforcement personnel.
- You must submit a separate request at each Pharmacy or Vision Center/Optical location from which you would like an accounting of disclosures.
- The accounting of disclosures will be provided to you within sixty (60) days unless you are notified in writing that an extension of up to thirty (30) days is needed.

Section 1: Patient Information

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

Section 2: Request Information

a. I would like an accounting of disclosures for the following time period (not to exceed 6 years):
b. From the following facility: (list Walmart and Sam's Club location, including city and state, store/club number, as well as whether the request pertains to Pharmacy, Vision Center/Optical, or Optometrist)

Section 3: Signature and Date

_____ Signature of Patient or Personal Representative	_____ Today's 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.)
<input type="checkbox"/> Check this box if the patient is deceased.	

For Store/Club Use Only

Send completed form to HIPAA Privacy. See POM/VCOG.1613 .		
Store/Club Number: _____	RPh/RDO/Optician/AOD Initials: _____	Date Sent to HIPAA Privacy: _____