Request To Access Protected Health Information

Complete this form to request access to protected health information (PHI).

GENERAL INFORMATION

Please print the following information:

Patient's Name _____ ☐ Male ☐ Female

Date of Birth _____ / _____ / _____

Mailing Address _____ City _____

State ____ Zip Code _____ Phone Number (_____) _____ - _____

PROTECTED HEALTH INFORMATION REQUEST INSTRUCTIONS

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules, I request to review protected health information (PHI) held by Publix Pharmacy # _____ about (check one) ☐ *me*, ☐ *my minor child*, ☐ *my legal dependant*, or ☐ *deceased individual*. This PHI is listed on a *Medical Expense Summary* report and includes information such as prescription, billing, and insurance records.

I request access to PHI covering the dates of _____/_____/_____ through _____/_____/_____.

AGREEMENT

I understand that

- the Pharmacy cannot give PHI requested to anyone other than the patient, the patient's legal guardian, or the patient's personal representative
- if the patient, the patient's legal guardian, or the patient's personal representative is unable to personally pickup the PHI, it will be mailed to the patient's address listed above
- the Pharmacy has 30 days to respond to this request, and if someone else holds the PHI I'm requesting or it is off-site, the Pharmacy has 60 days to respond (except for Pharmacies located in Tennessee, which have 10 days to respond)
- the Pharmacy may charge a reasonable cost-based fee for providing this service
- this request does not apply to PHI that is (1) held by other Publix Pharmacy locations (2) compiled in reasonable anticipation of, or for litigation; and (3) not subject to the right to access under HIPAA Privacy Rules and
- the requested PHI will be provided in the form and format requested, if readily producible; otherwise, in a readable hard copy format, electronic format or other format agreed to by Pharmacy and you.

PATIENT SIGNATURE

Patient or Personal Representative's Signature _____

Date of Request _____ / _____ / _____

IF YOUR REQUEST IS DENIED

You may file a complaint regarding your request denial with the Pharmacy or the Department of Health and Human Services. If you file a complaint with the Pharmacy, please send it to:

Publix Super Markets, Inc.
Attention: Privacy Officer
PO Box 407
Lakeland, FL 33802-0407

Photo identification verified by (Pharmacy Associate Name) _____

Pharmacy Associate Signature _____ Date verified_____ / _____ / _____

Pharmacy's Response to Request Access to PHI

This side of the form is to be completed by the Pharmacist only.

RESOLUTION TO THE ACCESS REQUEST

Please check the appropriate resolution:

☐ The access request has been **granted**. *(Check one of the below.)*

- ☐ The Pharmacy will print the *Customer Statement* report for the dates indicated on the reverse side of this form.
- ☐ The Pharmacy will fax this request to the Corporate Pharmacy Department @ (863) 616-5846 because the records are older than what is maintained at retail.
- ☐ The Pharmacy will fax this request to the Corporate Pharmacy Department @ (863) 616-5846 because the patient has requested the records in electronic format.

☐ The access request has been **denied** for the following reason(s):

_____

_____

_____

_____

If the request is denied, provide a copy of this form to the patient and the Privacy Officer.

The patient has the right to have the denial reviewed by a licensed health care professional that is designated by the Pharmacy to act as a reviewing official and who did not participate in the original decision to deny access. If the patient would like the denial reviewed, please check the appropriate box.

☐ Yes, the patient **would** like the denial reviewed.

☐ No, the patient **would not** like the denial reviewed.

Completed by _____ Date _____ / _____ / _____

Pharmacist Name

_____

Pharmacist Signature