



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

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City	State	Zip Code
	█	█

Phone Number

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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** _____

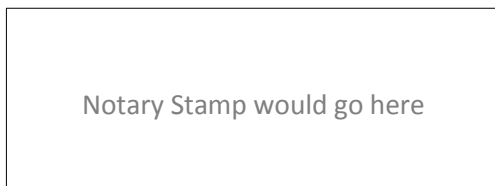
If a personal representative is signing for the customer, please indicate your relationship to the patient:

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: _____



OR

