

Webb's FAMILY PHARMACY

724 Main Street, Rochester, IN 46975 (574) 223-2216
101 W. Rochester Street, Akron, IN 46910 (574) 893-4413

Prescription Drug Summary Report Request (Request for Access to Protected Health Information)

NOTICE: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that you be allowed access, with some limited exceptions, to our records containing your Protected Health Information/Individually Identifiable Health Information (collectively referred to herein as "PHI").

Date of Request _____

I, _____ do hereby request Webb's Family Pharmacy to provide me with a PRESCRIPTION DRUG SUMMARY REPORT for the following date range:

Starting Date: _____ Ending Date: _____

I request that Webb's Family Pharmacy (*please check one*):

- allow me to inspect my PRESCRIPTION DRUG SUMMARY REPORT at the pharmacy during normal business hours.
- make photocopies of my PRESCRIPTION DRUG SUMMARY REPORT for me to pick up at the pharmacy during normal business hours, and for which I agree to pay a reasonable, cost-based fee.
- make photocopies of my PRESCRIPTION DRUG SUMMARY REPORT and mail to me at the address provided below, and for which I agree to pay a reasonable, cost-based fee.
- I authorize _____ to pick up my PRESCRIPTION DRUG SUMMARY REPORT.
- Other: _____

(Use this option if you wish to receive your PRESCRIPTION DRUG SUMMARY REPORT in some other format or by some other manner, such as electronic mail or fax. Please consult with our Privacy Officer about our ability to provide your PRESCRIPTION DRUG SUMMARY REPORT in this requested manner.)

I understand that any use or disclosure of my PRESCRIPTION DRUG SUMMARY REPORT that I make, whether intentional or unintentional, after reviewing or obtaining copies of the requested PRESCRIPTION DRUG SUMMARY REPORT is my responsibility.

Signature of Person Submitting Request

Date

Telephone Number

Street Address for Mailing: _____

City, State, and Zip Code: _____