

NOTICE: THERE IS A \$1.00 CHARGE PER PAGE

INDIVIDUAL REQUEST for ACCESS to RECORDS

NAME. <u>“Each person 18 years and above must sign their own form”.</u>	Date of Birth
Address	Telephone #

Please mark the records you are requesting access to:

Prescription & Payment information

I am requesting a copy of my records for the following specific date range: (must specify day)

From: XX/XX/XXXX _____ To: XX/XX/XXXX _____

For Example: 01/01/2009-12/31/2009)

Effective April 14, 2003, the pharmacy will retain PHI/records and associated documents for six (6) years from the date of last action.

If access to records is granted I would like my requested records:

Available for pickup at the pharmacy.

Mailed to the address listed above

Faxed to# _____

(VISA CARD - ADVANCED PAYMENT)

I understand that if the pharmacy grants access to records, the pharmacy will provide the requested records within thirty (30) days from receipt of the request. Also, I understand there may be a cost-based fee charged to process this request and the pharmacy will contact me prior to continuing action on this request for my acceptance of the fee amount (if any).

Date Signature of Individual/Legal Representative Legal Representative's Authority
(Relationship to Individual)

RECEIVED BY:

Date Signature of Individual/Legal Representative Legal Representative's Authority
(Relationship to Individual)

You may file the completed request with the Pharmacy or Mail to:
Thomas Greco, Manager, 438 US Highway 206 Hillsborough, NJ 08844
FAX to # 908-359-7278

Office Use Only – Please Do Not Write In This Space		<input type="checkbox"/> Fee – Amount \$ _____
Date _____	<input type="checkbox"/> Access Granted <input type="checkbox"/> Mailed Date _____	<input type="checkbox"/> FAXED Date _____
	<input type="checkbox"/> Access Denied because:	_____ Initials
	<input type="checkbox"/> NO RECORDS AVAILABLE FOR DATES REQ.	