PATIENT ACCESS REQUEST

This form is for a patient who wants a copy of his or her complete set of pharmacy records maintained in the Rite Aid Dispensing System. The record will be mailed to the patient's address shown in the pharmacy record.

This form is NOT necessary if a patient seeks only a "medical expense statement" (for income tax purposes, for example). The pharmacist may provide such a statement only to the patient or to his or her legal personal representative (See categories below). However, if the patient or their legal personal representative is not present in the pharmacy, the statement will be mailed to the patient at the address shown in the pharmacy records.

I wish to receive a copy of Rite Aid's Designated Record Set, as defined in Section 164.501 of the HIPAA Privacy Regulation, which contains my Protected Health Information.

I am the patient who is the subject of that record or I am that patient's personal legal representative as indicated below.

Under certain, limited circumstances, a request for access may be denied. If your request is denied, we will notify you in writing and you will have an opportunity to have the denial reviewed

(Please Print Clearly)

Name of the Patient ____

Street Address ____

City____ State _________

Zip Code_____________________ Telephone Number ___________________________________

Date of Birth _____________________

If other than patient or parent, proof of authority to sign must accompany this form.
❑ Patient ❑ Parent or Guardian ❑ Power of Attorney ❑ Court Appointed

Signature ____ Date ______________________

Print Name ____

Mail to:
Privacy Office, Rite Aid, P.O. Box 3165, Harrisburg, PA 17105.

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