

# Pharmacy Form Request for Confidential Communications

## What is the Purpose of this Request?

This form is used by a Patient or Patient's personal representative to request that communications of a Patient's Protected Health Information ("PHI") be received from the Wal-Mart, SAM'S Club, and Neighborhood Market Pharmacies (collectively "Pharmacy") by alternative means or at alternative locations. Your request may be denied if it cannot reasonably be accommodated. It may also be denied unless the disclosure of your PHI could endanger you.

#### Section 1: Patient Information (as listed in the Patient profile)

Patient Name:				Date of Birth:				
Address:								
City:	State:	Zip:		Phone:				

#### Section 2: Communication Method

	al the line below that describes how you would lik rmation from the Pharmacy:	e to receive commun	ications of Protected Health
(a)	Telephone		
-	The phone number(s) I may be contacted at is:	( ) ( )	
(b)	Mail		
-	The alternate address I may be contacted at is: Address:		
	City:	State:	Zip:
(c)	The Pharmacy may contact me by the follo	wing method (be spec	cific):

### Section 3: Signature

Please note that if you request confidential communication, the Pharmacy will send all correspondence to you at the address you supply and/or will call you at the alternative phone number you supply. We will continue to do so until you advise us in writing that would like to use another method of communication. If you would like to change this method of communication, you must fill out a new form with your new contact information.

Signature of Patient or Personal Representative

Today's Date

If you have signed this form as a legally authorized representative of the Patient, please print your name and relationship to the Patient below.

Name of Personal Representative (please print)

Relationship to Patient (parent, legal guardian, etc.)

#### For Office Use Only

Request St	atus:	Approved	Denied		
				Date	RPh Initials
Reason:					
-					
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