Request for Amendment

This form is intended to accommodate different situations when patients want to change the Protected Health Information (PHI) in the Rite Aid Dispensing System, modify the use of any PHI, request disclosure of PHI, or restrict the use or disclosure of PHI, as applicable.

I request that Rite Aid **change**, **disclose**, or **restrict** my Protected Health Information (PHI) as described below. I understand that my records will be amended after Rite Aid has processed my request and that, in certain cases, Rite Aid may deny this request.

Name of the Patient (PRINT) _____

Street Address _____

City_____ State _____

Zip Code_____ Telephone Number _____

Date of Birth _____

Name of the person making the request (If different from the patient – attach POA or Guardianship forms):

_____

Street Address _____

City_____ State _____

Zip Code_____ Telephone Number _____

Nature of the Change/Modification/Disclosure/Restriction requested:

❑ Change of Custodial Parent ❑ Estate Executorship for Deceased Individual

❑ Power of Attorney ❑ Court Appointment to Represent Incapacitated Person

❑ Restrict the use of my (brief description required) PHI

(Please note, so long as the request is not required by law and you pay in-full out of pocket, Rite Aid will honor any affirmative request not to disclose PHI to a health plan.)

_____

_____

_____

❑ Other (Brief Description) _____

_____

Documentation Supporting Reason for Amendment Request: (Please attach if applicable)

_____

I am the patient or the patient's legal personal representative as indicated below.
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
or fax to: 717-975-5952