Rite Aid Privacy Office
Privacy Office, Rite Aid, P.O. Box 3165, Harrisburg, PA 17105; Fax Number: 717-975-5952
Online Request Form available at: www.riteaid.com/legal/request-records

REQUEST TO ACCESS, INSPECT, OR OBTAIN PROTECTED HEALTH INFORMATION

Request:

I request to review health information held about me in the Rite Aid "designated record set" in accordance Section 164.501 of the HIPAA Privacy Regulation. I understand that Rite Aid has 30 days to respond to this request, Rite Aid may extend this 30 day response period for another 30 days, and in certain circumstances Rite Aid may deny my request. This form is NOT necessary if a patient seeks only a "medical expense statement" (for income tax purposes). The pharmacist may provide such a statement only to the patient or to his or her legal personal representative if either is present in the pharmacy.

Information:

Please fill out this section if records are going to a third party

Patient Name: _____
Date of Birth: _____
Street Address: _____
City, State, Zip: _____

Telephone Number: _____
E-mail Address: _____

Third Party Recipient: _____
Relationship: _____
Street Address: _____
City, State, Zip: _____

Telephone Number: _____
E-mail Address: _____

Method for receiving your health information: (check only one box below)

____ Email (Encrypted): In an effort to protect your health information, our standard practice is to encrypt our email.

____ Email (Unencrypted): By signing you acknowledge that you understand an unencrypted email exposes your personal and health i information to additional security risks.

We may be able to accommodate your request at an additional charge.

Agreement:

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
- I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law.
- 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.
- This authorization will last for six months of the date of my signature unless I expressly reference a date here _____
- If applicable, a fee may be assessed to provide such records

Signature

Signature _____ Date: _____
Printed Name: _____

If signed by the patient's personal representative, explain authority to act on behalf of the patient:

Note: If you are signing this form as the legal representative of the individual listed above, and are other than the parent of the minor child whose information is listed above, you must also submit documentation that establishes yourself as the legal representative. For example, a copy of a Power of Attorney that includes provisions to obtain medical information, etc.

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