# Request to Access Records

| ***What Patient?*** | |
|---|---|
| Patient Name | Date of Birth |
| Address | Telephone # |

| ***For What Time Period?*** | |
|---|---|
| I am requesting data for the following timeframe (you may be able to go back six (6) years). | Start Date: _____ End Date: _____ |

***What Information?***

Please describe the Information you wish to have access to and in what format (we will try to comply with the format if possible):

☐ Medication Expense

☐ Other (Please provide detail)

***Who do you want information sent to?***

☐ Myself

☐ Individual or Entity (Please provide name, address, and instructions to send information)

If the records are being requested for a spouse, child that is above the Age of Medical Consent or other individual, they will be mailed directly to the patient.

*I understand that if the Facility grants access to records, they will provide the requested records within thirty (30) days. Also, I understand there may be a cost-based fee charged to process this request and the Facility will contact me prior to continuing action on this request for my acceptance of the fee amount (if any). If the Facility needs additional time, then the Facility's Privacy Officer will notify me with the reason.*

When completed, please return to Community Pharmacy Services Inc.
Or Mail to:
Community Pharmacy Services Inc.
21689 Northstar Drive
Gretna, NE 68028

| Signature of Patient/Legal Guardian/Personal Representative. | Relationship to the Patient. | Date |
|---|---|---|
| | | |

CLEAR SUBMIT