Medical Park Pharmacy LTC

Request to Access Protected Health Information

I, _____, do hereby request access to my confidential or protected health information contained in the following pharmacy records (check one or both):

- ❑ Profile of prescriptions filled from _____ to _____.
  Beginning date Ending date
- ❑ Other (please indicate information requested below).

  _____
  _____
  _____

I request to have copies of the records mailed to me at the address provided below.

I understand that Medical Park Pharmacy LTC will respond to my request in accordance with the Administrative Rules of the Health Insurance Portability and Accountability Act of 1996, published in the Federal Register and outlined in Medical Park Pharmacy LTC's policies and procedures.

_____ _____
Signature of Person Submitting Request Date

I request to have copies of the records mailed to me at the address provided below.

Street Address for Mailing: _____

City, State and Zip Code: _____

Telephone Number: _____