Women's International Pharmacy

Custom Compounded Prescriptions for Men and Women

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

I hereby request access to Protected Health Information (PHI) maintained by Women's International Pharmacy, Inc. for the purpose of inspection and/or obtaining copies. **Please note: Records will be sent by the method indicated below or may be picked up, in person, at the pharmacy, unless the person requesting PHI is an agent of the patient or the patient is requesting records be sent to another person.**

Patient Name: ______________________ Patient Date of Birth: ______________

Patient Address: ____

Patient City: ______________________ State: ____________ Zip: ________

Patient Telephone Number: ______________ Patient Fax Number (if applicable): ________

Patient Email (if applicable): ______________________________________

To be completed only if patient is requesting PHI be sent to another person:

Person's name receiving PHI: ______________________________

Person's address receiving PHI: ______________________________

Person's email receiving PHI (if applicable): ____________________

Person's fax number receiving PHI (if applicable): ______________

To be completed only if patient's legal representative is requesting PHI (provide proof of legal authority):

Name of Legal Representative: ______________________________

Address of Legal Representative: ____________________________

Telephone Number of Legal Representative: ____________________

Email of Legal Representative (if applicable): __________________

Fax Number of Legal Representative (if applicable): ______________

Information Requested: ______________________________________

From ______________________ to ______________________

(Starting date) (Ending date)

Format Requested (e.g., mail, email, fax, etc.): ______________________

Please ensure the appropriate address, email address, fax number, etc. is provided above

Signed: ______________________________ Date: ______________

(Patient or Legal Representative* signature)

***If a legal representative of the patient signs the form, please also include one of the following:**
(1) a copy of the signed Power of Attorney, (2) other proof of legal authority, or (3) a signed patient release form.