Request to Access Records

Patient Name	Date of Birth
Address	Telephone #

Must be completed for each patient

☐ I would like a **Medication Expense Report** for the following Years:	Year(s):
☐ I would like the following **individuals to pick up** my expense report from the pharmacy:	
☐ I would like the following individuals to have **access to my online prescription profile** (This gives access to ALL facility health records):	Start Date:_____ End Date:_____
☐ Please describe the Information you wish to have access to and in what format (we will try to comply with the format if possible):	I am requesting data from the following time frame Start Date: _____ End Date: _____

If the records are being requested for a spouse or a child that is above the Age of Medical Consent, they will be mailed directly to the patient's address currently on file.

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 (no fees apply to first three boxes). If the Facility needs additional time, then the Facility's Privacy Officer will notify me with the reason.

When completed, please return to CUSTOMEDICA PHARMACY
Or
Email to: info@customedica.com
Or Mail
CUSTOMEDICA PHARMACY
149 W STATE ST SUITE 101
Eagle, ID 83616

Signature of Patient/Legal Guardian/Personal Representative.	Relationship to the Patient. ☐ Self ☐ Legal guardian ☐ Personal representative/Power of attorney	Date