# Balls Food Stores

## PROTECTED HEALTH INFORMATION REQUEST FORM BY PATIENT

(Please check one box below per request. Reasonable fees may be imposed when applicable.)

☐ Request for inspection and copy of Protected Health Information. **(submit directly to Pharmacy)**

☐ Request for an amendment to Protected Health Information. **(mail to Privacy Officer)**

☐ Request for accounting of disclosures of Protected Health Information. **(mail to Privacy Officer)**

☐ Restriction on use and disclosure of Protected Health Information. **(mail to Privacy Officer)**

☐ Request communication of Protected Health Information by alternative means or at alternative location. **(submit directly to Pharmacy)**

***Please Print***

Patient Name: _____ _____ _____

(Last) (First) (MI)

Address: _____

City, State, Zip: _____

Phone Number: _____ D.O.B. _____

*Location of Protected Health Information*

Name of Pharmacy: _____

Address: _____

City, State, Zip: _____

Description of Request _____

_____

_____

_____

_____

Patient's Signature: _____ Date: _____

***If request is being made by someone other than the patient:***

Name: _____ _____ _____

(Last) (First) (MI)

Address: _____

City, State, Zip: _____

Phone Number: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Authorizing Patient Signature: _____ Date: _____

Date Needed/Effective Date: _____

Instructions for Mailing or Pick Up At Pharmacy: _____

_____

_____

**Please mail completed request to: (when applicable)**

**Balls Food Stores**
**Attn: Privacy Officer**
**5300 Speaker Road**
**Kansas City, KS 66106**

**Received By:** _____

**Date Received:** _____