Exact Care Pharmacy

Request to
ACCESS PATIENT RECORDS

Section 1: Patient's Personal Information

Name: ______________________ DOB: ______________________

Address: ______________________ Telephone: ______________________

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Section 2: Proof of Identity

☐ Driver's License: ______________________ ☐ Passport Number: ______________________

☐ Guardianship Documentation: ______________________

☐ Covered Entity Request for Documentation: ______________________

I understand that upon granting access to requested records, the facility will provide these records within thirty (30) days of receipt of request. In addition, I understand there may be a cost-based fee charged to process this request. The facility will contact me prior to continuing action on this request for my acceptance of the fee amount.

Effective April 14, 2003 *the facility retains PHI records and associated documents for six (6) years from the date of last action.*

Section 3: Request for PHI Information

☐ Patient File
☐ Payment Information
☐ Insurance Data
☐ Prescription/Medical File
☐ Prescription Hard Copy
☐ Other

Format Requested:

☐ Hard Copy
☐ Electronic Format
☐ Other

I understand there may be a fee assessed for providing my request which would include: SUPPLIES, LABOR AND POSTAGE.

Patient Signature: ______________________ **Date:** ______________________

Legal Representative/Guardian Signature: ______________________ **Date:** ______________________

Relationship to Individual: ______________________

Submit this completed request to the facility or mail to:

Exact Care Pharmacy
Todd Donnelly, RPh
8333 Rockside Rd
Valley View, OH 44125-6126

***Office Use Only* – Please Do Not Write Below This Space**

Date Request Received: ______________ Date Approved: ______________ Fee for Service: Yes/No

Date Provided to Patient: ______________ Format Provided: ______________ Total Cost: ______________