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:	
☐ Please describe the Information you wish to have access to and in what format (we will try to comply with the format if possible): All Pharmacy Records	I am requesting data from the following time frame (you may be able to go back six (6) years). Start Date: _____ End Date: INDEFINITELY
☐ I would like the following Individuals to have access to my facility health records. Please describe the type of records: Start Date: _____ End Date: INDEFINITELY	

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.

I understand that if the pharmacy grants access to records, they will provide the requested records within thirty (30) days or sixty (60) days if the records are maintained off-site from the receipt of the request. Also, I understand there may be a cost-based fee charged to process this request and the pharmacy will contact me prior to continuing action on this request for my acceptance of the fee amount (if any). If the pharmacy needs additional time, then the pharmacy's Privacy Officer will notify me with the reason.

When completed, please return to Atkinson Mart, Inc.

Or Mail to:

Atkinson Mart, Inc

1994-A Kingsley Ave.

Orange Park, FL 32073

(904) 269-8079 (FAX)

Signature of Patient/Legal Guardian/Personal Representative.	Relationship to the Patient.	Date