Haworth Apothecary
169 Terrace St
Haworth, NJ 07641

REQUEST for ACCESS to RECORDS

Name of Individual	Date of Birth
Address	Telephone #

Please mark the records you are requesting access to:

- ☐ Patient File (Demographic Information)
- ☐ Insurance Data
- ☐ Prescription Profile
- ☐ Payment Information
- ☐ Prescription Hardcopy
- ☐ Other

I am requesting a copy of my records for the following time frame:

From:_____ **To:**_____

Effective April 14, 2003, the pharmacy will retain PHI records and associated documents for six (6) years from the date of last action.

I am requesting the following individuals have access to my PHI and medical records:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

If access to records is granted, the pharmacy will provide a hardcopy of the requested records. If you wish to receive the requested records in a different format (i.e. E-mail, disk) please specify:

_____

If access to records is granted, I would like my requested records:

☐ Mailed to the address listed above. ☐ Available for pickup at the pharmacy.

I understand that if the pharmacy grants access to records, the pharmacy will provide the requested records within thirty (30) days from 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).

_____ _____ _____
Date | Signature of Individual/Legal Representative | Legal Representative's Authority (Relationship to Individual)

You may file the completed request with the Pharmacy or Mail to:
Haworth Apothecary

169 Terrace Street, Haworth, NJ 07641

Office Use Only – Please Do Not Write In This Space

Date Rec'd:_____ ☐ Access Granted ☐ Access Denied ☐ Notice Mailed to Individual

☐ Fee – Amount $ _____
☐ Individual accepted
_____Initials