

Request to Access Records Sebastopol Family Pharmacy, Inc.

What Patient?	
Patient Name	Date of Birth
Address	Telephone #
For What Time Period?	
I am requesting data for the following timeframe (you may be able to go back six (6) years).	Start Date: _____ End Date: _____
What Information?	
Please describe the Information you wish to have access to and in what format (we will try to comply with the format if possible):	
<input type="checkbox"/> Medication Expense <input type="checkbox"/> Other (Please provide detail)	
Who do you want information sent to?	
<input type="checkbox"/> Myself	
<input type="checkbox"/> Individual or Entity (Please provide name, address, and instructions to send information)	

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 unless specified above.

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 (if any). If the Facility needs additional time, then the Facility's Privacy Officer will notify me with the reason.

When completed, please return to Sebastopol Family Pharmacy Inc.

Or Mail to:

Sebastopol Family Pharmacy, Inc.
 1652 Petaluma Ave., STE i1
 Sebastopol, CA 95472

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