

SHAW'S SUPERMARKETS / STAR MARKET

CUSTOMER REQUEST FORM

AMENDMENT OF PHARMACY RECORD(S)

Request for amendment of demographic information.

Old:

Patient Name: _____ Date of Birth: _____
Address: _____ Phone #: _____
City, State, Zip: _____

I am requesting the demographic information in my pharmacy record be changed to the new information I have listed below:

New:

Patient Name: _____ Date of Birth: _____
Address: _____ Phone #: _____
City, State, Zip: _____ Marital Status: _____
Allergies/Disease State: _____

Request for an amendment of my pharmacy record.

After review of my pharmacy record, I do not feel that the original documentation made by _____ (pharmacy location/address) accurately reflects the pharmacy services rendered on the following date _____ and should be supplemented with clarifying information in the form of an addendum to my pharmacy record.

I understand that Shaw's Supermarkets / Star Market may or may not supplement my record with an addendum based on my request. I understand that Shaw's Supermarkets / Star Market is not allowed to alter previous documentation in my record. I understand that my request for an amendment will be made a permanent part of my pharmacy record and, upon my request, will be sent with any future authorized request for information.

I understand that Shaw's Supermarkets / Star Market will provide a response to this request within sixty days. I understand I have the opportunity to provide a statement of disagreement should Shaw's Supermarket / Star Market deny my request.

Reason for amendment: _____

I request the following correction/amendment be made to my pharmacy record:

Upon acceptance of your request for amendment of your pharmacy record, a correction/addendum will be made part of your permanent pharmacy record. Shaw's Supermarkets / Star Market will forward the amended records to our business associates that have the protected health information that is the subject of the amendment, and to individuals you indicate below that have the protected health information about you and need the amendment.

Name: _____ Name: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____

Signature: _____ **Date:** _____

Please Note: Form must be completed in full to process your request.

You may submit this form at any Shaw's Supermarkets/Star Market Pharmacy location, or you may mail it to: Director of Pharmacy, Shaw's Supermarkets/Star Market, Inc., P.O. Box 600, East Bridgewater, MA 02333

REQUEST FOR AMENDMENT OF PHARMACY RECORD

| | | |
|---------------------------|--|--------------------------------|
| Pharmacy Use Only | | Pharmacy # _____ |
| Accepted | Patient notified of change? Yes _____ or No _____ Private charge customer? Yes _____ or No _____ Shaw's Supermarkets / Star Market pharmacies used by customer: _____ | |
| Denied | _____ Not created by Shaw's Supermarkets / Star Market. _____ Not part of designated record set. _____ Does not have right to access information: _____ Patient is an inmate and the information requested could jeopardize the health, safety, security, custody or rehabilitation of the patient or others. _____ Information is subject to the Privacy Act, which authorizes denial of your request. _____ Information requested was obtained from a third party (non-healthcare provider) under a condition of confidentiality. _____ Information is compiled in anticipation of judicial or administrative proceedings. _____ Accurate and Complete _____ Other _____ | |
| Pharmacy Signature: _____ | | Date Processed: ____/____/____ |

| Director of Pharmacy Use Only | | |
|---|-----------|----------|
| | Date Sent | Initials |
| Customer Request #1 | _____ | _____ |
| Customer Request #2 | _____ | _____ |
| Pharmacy #: _____ | _____ | _____ |
| Pharmacy #: _____ | _____ | _____ |
| Pharmacy #: _____ | _____ | _____ |
| Pharmacy #: _____ | _____ | _____ |
| Accounting | _____ | _____ |
| Business Associate: _____ | _____ | _____ |
| Business Associate: _____ | _____ | _____ |
| Business Associate: _____ | _____ | _____ |
| Business Associate: _____ | _____ | _____ |
| Other: _____ | _____ | _____ |
| Other: _____ | _____ | _____ |
| Other: _____ | _____ | _____ |
| Other: _____ | _____ | _____ |
| Date response sent to patient ____/____/____ by _____ | | |

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