

SHAW'S SUPERMARKETS / STAR MARKET

CUSTOMER REQUEST FORM

ALTERNATIVE COMMUNICATIONS

I am requesting to receive confidential communications of my protected health information. In the future, I wish to receive communications of protected health information from Shaw's Supermarkets / Star Market by the alternative means or at the alternative location listed below. **Please Print.**

Patient Name: _____ Date of Birth: _____

Current Address: _____

Current Telephone Number: _____

Pharmacies Used: _____ (address/city)
_____ (address/city)
_____ (address/city)
_____ (address/city)

ALTERNATIVE MAILING ADDRESS REQUESTED:

Street address or P.O. Box _____

City, State, Zip _____

ALTERNATIVE PHONE NUMBER: (____) _____

SPECIFIC COMMUNICATION REQUEST: _____

Signature: _____ Date: _____

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

Pharmacy Use Only			
After updating the patient's record, note how the request was satisfied, initial and date the appropriate blank and forward to the Director of Pharmacy.			
Initials	Date Processed	Department	ID Verified by:
_____	_____	PHARMACY # _____	_____
Explain response taken: _____			

Director of Pharmacy Use Only			
Other Pharmacies: #s _____, _____, _____, _____, _____			

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