

SHAW'S SUPERMARKETS / STAR MARKET

CUSTOMER REQUEST FORM

RESTRICTIONS ON USES AND DISCLOSURES OF PHI

I am requesting that you restrict the uses and disclosures of my protected health information as I have described below. **Please Print.**

Patient Name: _____ Date of Birth: _____

Current Address: _____

Current Telephone Number: _____

Pharmacies Used:

_____ (address/city)
_____ (address/city)
_____ (address/city)
_____ (address/city)

REQUESTED RESTRICTIONS ON USES AND DISCLOSURE: _____

Please Note: We are not required to agree to any restrictions.

Signature: _____ Date: _____

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

Pharmacy Use Only			
Once this form is completed forward to the Director of Pharmacy.			
Initials	Date Processed	Department	ID Verified by:
_____	_____	PHARMACY # _____	_____
----- Director of Pharmacy Use Only			

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