

# BOUNTIFUL DRUG

47 East 500 South | T 801-295-3463  
Bountiful, UT 84010 | F 801-298-8223

Email: [pharmacy@bountifuldrug.com](mailto:pharmacy@bountifuldrug.com)

## Request to Access Protected Health Information Form

|  |   |
|--|---|
| Name of Patient (PHI Requested for)  | DOB   |
| Name of Person Making Request (if not Patient)   | Relationship to Patient (if not Patient)                            |
| Address  | Telephone Number  |
|  | Brief Description of PHI Requested (Dates & Medications to include) |
| Reason for Request   |   |
| Preferred Format of PHI<br><br>__ Paper Copy: __ Mail __ Pick-up<br><br>__ Digital Copy: __ Email __ Fax |   |

I hereby represent and warrant that I am requesting access to Protected Health information (PHI) for myself or as the authorized representative of the Patient. If I am not the Patient, I have the full right and legal authority to make such requested and receive the PHI herein requested on behalf of the patient noted above, and I agree that I will use and disclose the PHI only as permitted by the patient and applicable privacy laws.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date