College Pharmacy: Request to Access Records

Patient Full Name (PRINTED)	Date of Birth
Address / City / State / Zip	Telephone #

Must be completed for each patient.

☐ I would like a Medication Expense Report for the following Years:	
☐ Please describe the Information you wish to have access to and in what format (we will try to comply with the format if possible): Email Address, if requesting records emailed:____ Fax Number, if requesting records faxed:____	I am requesting data from the following time frame (you may be able to go back six (6) years). Start Date: ___________ End Date: ____________
☐ I would like the following Individuals to have access to my facility health records. Please describe the type of records. Please print clearly. Start Date: ___________ End Date: ____________	

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.

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 College Pharmacy, Inc.
College Pharmacy, Inc.
3505 Austin Bluffs Parkway, Suite 101
Colorado Springs, CO 80918
Fax: (800) 556-5893 / (719) 262-0035
Email: hipaamail@collegepharmacy.com

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