

**SHAW'S SUPERMARKETS / STAR MARKET**

**CUSTOMER REQUEST FORM**

**ACCOUNTING OF DISCLOSURES**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy Locations Used: \_\_\_\_\_

Please check this box if this request is for your minor child.

I request that Shaw's Supermarkets / Star Market provide me with an accounting of disclosures of my protected health information made by Shaw's Supermarkets / Star Market. I understand that I have the right to receive an accounting of disclosures made after April 14, 2003 for certain purposes other than treatment, payment, or health care operations and certain other permitted disclosures, for the six-year period prior to the date of my request (but not before 4/14/03). I understand the accounting will exclude certain disclosures, such as disclosures made directly to me, disclosures that I authorize, disclosures to friends or family members involved in my care, and disclosures for notification purposes. I also understand the right to receive an accounting is subject to certain other exceptions, restrictions, and limitations.

I am requesting an accounting of disclosures for the following dates:

From: \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_

I understand I may receive one free accounting of disclosures within any 12-month period, and I will be charged a cost-based fee for each additional accounting that I receive during that same 12-month period. I understand that Shaw's Supermarkets / Star Market will mail the requested accounting to me at the address above within sixty days.

\_\_\_\_\_  
Signature of Patient or Patient's Personal Representative  
(parent of minor child, legal guardian or legal personal representative)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient's Personal Representative (if applicable)

\_\_\_\_\_  
Relationship to the Patient

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

Director of Pharmacy Use Only				
Date Request Received: ___/___/___				
Business Associate	Date Requested	Initials	Date Received	Initials
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Accounting of Disclosures Statement sent to patient: ___/___/___ by _____				

**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**