TOPS MARKETS, LLC [Insert Logo]

HIPAA REQUEST/AUTHORIZATION FORM

This form is to be used by pharmacy customers of Tops Markets, LLC ("Tops" or "we") who wish to make any of the following Requests or Authorizations relating to their Protected Health Information ("PHI"):

- Authorize Disclosure of PHI
- Request Restrictions of Disclosure of PHI
- Request Access to PHI
- Request an Amendment of PHI
- Request an Accounting of PHI
- Request Communications by Alternate Means
- Agree to the Disclosure of Immunization Records

Please complete the customer information below and sign where indicated, then check the box for each Request or Authorization you wish to make and complete each applicable section. Once completed, submit this form to the Tops Privacy Officer by e-mail OR U.S. Mail, at:

privacyofficer@topsmarkets.com **OR** **Tops Markets, LLC**
Attn: Privacy Officer
P.O. Box 1027
Buffalo, NY 14240

Customer Name: _____ Date of Birth: _____

Address: _____*

Phone: _____ *

* I authorize Tops Markets, LLC to contact me regarding this form at this address and phone number

Customer Signature: _____ Date: _____

☐ **Authorize Disclosure of PHI**

I authorize Tops to disclose my PHI to the following individual(s):

Name: _____ Address:_____ Phone: _____
Name: _____ Address:_____ Phone: _____
☐ No Restrictions ☐ Prescription profile for time period: _____

NOTE: Tops will only disclose PHI that is directly relevant to the identified individual's involvement in your care, and otherwise in accordance with applicable law.

☐ **Request Restrictions on Disclosure of PHI (**please check each that applies)

___ I request that my PHI not be disclosed to my family members, close friends or others involved in my care.
___ I request that my PHI not be used or disclosed for treatment, payment or health care operations.
___ I request that my PHI not be disclosed to my health insurance company for payment or health care operations purposes. I understand that Tops is required to agree to this restriction only to the extent the PHI relates to a health care item or service I receive that is paid for in full by someone other than my health plan.

Please provide detail on the specific PHI you wish to be subject to the restriction. Tops cannot agree to a blanket restriction, and will require a new request prior to each provision of services or items:

_____
_____

NOTE: Tops is not required to agree to your request, except as stated above. If we do agree to your requested restriction, we will comply with your request except as needed to provide you with emergency treatment or in accordance with federal and state law. We may terminate your requested restriction if you agree to the termination orally or in writing. We may also terminate certain restrictions upon notice to you, except that such termination will only be effective for PHI created or received after we have notified you.

☐ **Request Access to PHI**

I would like to inspect or obtain a copy of my PHI (please explain your request):

___ I would like to inspect my PHI (Tops will contact you to arrange for inspection)

___ I would like to obtain a copy of my PHI (Please describe the form and format in which you would like the PHI to be delivered. For instance, indicate if you would like the information delivered by e-mail or U.S. Mail, any particular format you request, and your e-mail or mailing address. If a copy is to be sent to another individual, please include his/her name. Attach additional pages if needed):

_____
_____

NOTE: Tops may deny your request in certain circumstances. If required by law, we will provide you with a written explanation and you may have an opportunity to request a review of the denial. If Tops complies with your request, we may contact you to arrange for alternative methods or formats of delivery, as permitted by law. We may charge you a reasonable fee for the costs of preparing, copying and mailing the requested information.

☐ **Request an Amendment of PHI**

I request the following amendment to my PHI (Please describe the amendment request in detail, and the reason for the request. You may attach additional sheets to this form if necessary. Please also attach any backup documentation you may have to support your request):

_____
_____
_____
_____
_____

NOTE: Tops may deny your request for amendment in accordance with our Notice of Privacy Practices. If we deny your request for amendment, we will give you a written denial including the reasons for the denial and you will have the right to submit a written statement disagreeing with the denial.

☐ **Request an Accounting of PHI**

I request an "accounting" of disclosures of my PHI. I understand that this is a listing of disclosures made by the Pharmacy or by others on my behalf, but does not include disclosures for treatment, payment and health care operations, disclosure made pursuant to my Authorization, and certain other exceptions.

Please complete the following:

- Accounting time period (must be within six years of the date of this request):
  From:_____ To:_____
- Location(s) of all Tops pharmacies for which I am requesting an accounting:
  _____
  _____
  _____

NOTE: The first accounting provided by Tops within a 12-month period will be free; for further requests, we may charge you our costs. We will notify you of our costs and you may choose to withdraw or modify your request at that time.

☐ **Request Communications by Alternate Means**

I request that you communicate with me regarding my health matters as follows (Please describe your requested communication methods and contact information. For example, you may request that we contact you via e-mail only, or at your work address instead of your home address):

_____
_____
_____

NOTE: Tops will accommodate your reasonable requests. We may require further information before implementing your request, but we will not ask you to explain the reason for your request.

_____

☐ **Disclosure of Immunization Records**

I request and consent to the disclosure of the immunization records of:

Patient Name: _____ Patient Date of Birth: _____

To the following school: School Name: _____
Address: _____
_____
_____
Attention: _____

If you are not the patient, please print your name and describe your relationship to the patient:

_____ _____
Print Name Relationship to patient