Pharmacy Record Release Form *(Return via mail or fax)*

☐ Paper (I understand that all records will be mailed unless specified)

☐ Electronic: _____

☐ Fax: _____

The purpose of this request:

☐ Personal Request ☐ Treatment (Continued Care)

☐ Other: _____

Request access and/or disclosure of Patient Prescription records for the following dates of service:

_____

Patient Signature: _____ Printed Patient Name: _____

LAP Signature: _____ Print Name: _____

Witness Signature: _____ Print Name: _____

Date: _____

Phone: _____

Request for Access has been:

☐ Granted ☐ Partially Denied ☐ Denied

If access is denied and patient requests review of denial, contact the Release of Information office below. Medical Records released/accessed:

Date: _____ By: _____

Send to Release of Information:
Email: : GLR.SPS@adventhealth.com or **Fax:** 630-856-3992
Mailing Address: UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy
500 Remington Blvd, Bolingbrook, IL 60440 | Phone: 833-670-7171