EXPRESS SCRIPTS®

Individual Request for Access to Electronic Protected Health Information

This form will allow me to request access to my Protected Health Information (PHI) that an Express Scripts entity maintains.

Select Entity (select only one)

☐Express Scripts Home Delivery

☐Express Scripts PBM

1. Verification

Individual for whom records are being requested:

Patient First Name: _____

Patient Last Name: _____

Patient Middle Name: _____

Patient Date of Birth: _____

Address on Record:

Address Line 1: _____

Address Line 2: _____ City: _____ State _____ Zip _____

Member/Insurance ID card # (if applicable): _____

Name of Member/Cardholder: _____

Phone number on record: (_____) _____ -_____

Request made by: _____

Relationship (Self, Personal Representative) _____

2. Request

Information Requested from Records

☐ Electronic Medical Record – Defined by USCDI/ONC Data Requirements

Information will be provided via secure e-mail in Machine-Readable Format (JSON)

3. Completed Records

Send completed records to me:

Email: _____ Confirm Email: _____

Send completed records to another location:

I understand that I [(or my personal representative)] have the right to direct the entity to disclose my encounter data, claims data, and clinical data (collectively, health data) held by the entity to a designated third party, including a third-party that holds information for my personal use.

Email: _____ Confirm Email:_____

_____

Signature by Individual/Representative

Phone number where we can reach you if we need to contact you to process your request (if different than number on record):_____