TEMPLATE 04 · MYCHARTCOUNT GUIDE

Pharmacy (Medication Fill History)

WHEN TO USE

Requesting your complete medication fill history from a pharmacy. Pharmacy records are usually the most accurate record of what medications you have actually taken — more complete than what's in any single doctor's office.

[Your Full Legal Name]

[Your Street Address]

[City, State ZIP]

[Phone] · [Email]

[Today's Date]

[Pharmacy Name and Chain]

Attn: Pharmacy Manager / HIPAA Privacy Officer

[Pharmacy Address]

[City, State ZIP]

Re: Request for Complete Prescription Fill History

Patient: [Your Full Legal Name]

Date of Birth: [Your DOB]

Patient ID / Loyalty Card Number (if any): [number]

To Whom It May Concern,

Under my right of access in HIPAA (**45 CFR § 164.524)**, I am requesting a complete copy of my prescription fill history from your pharmacy, including (if available across the entire chain or only at this location, please indicate):

- All prescriptions filled, with dates, drug names, strengths, dosage forms, quantities, days' supply, and prescribers
- All refill records
- All immunizations administered at the pharmacy

- All medication therapy management (MTM) records
- All counseling notes and pharmacist consultations
- All insurance claims submitted on my behalf

If your records system can produce a printout covering ALL of my fills from your chain (not just this single location), please do so. If your system only covers this single location, please indicate that limitation in your response.

Please provide the records electronically as a PDF to my email at [your email].

Under HIPAA, you have 30 days to respond. You may charge only a reasonable, cost-based fee per HHS guidance.

For identity verification, I have attached a copy of my government-issued photo identification.

If you require additional verification, please contact me at [phone] or [email].

Sincerely,

_____

[Your Signature]

[Your Printed Name]

[Date]