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AUTHORIZATION – FOR RELEASE OF INFORMATION TO THIRD PARTY

This Authorization is for use, pursuant to the HIPAA privacy rules, if you are authorizing the release of medical/health information to a third party, such as a housing authority, insurance company, or law office. You understand these records may contain information created by other persons or entities, including physicians and other health care providers as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (excluding psychotherapy notes), reproductive health services, and treatment for sexually transmitted diseases.

Section 1: Patient's printed information

Last name | First name | MI

DOB

Street address

City | State | Zip code

Telephone

( ) -

Email address

List the location you obtain most of your prescriptions: _____

Section 2: Person authorized to receive information

Last name | First name | MI

Street address

City | State | Zip code

Telephone

( ) -

Email address

Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Caregiver ☐ Other (list):_____

Section 3: Describe or list the information that you are asking us to release

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Section 4: List the specific purpose for requesting this information

Section 5: Expiration required (see instructions)

This authorization expires: ☐☐/☐☐/☐☐☐☐ or event: _____

For Maryland residents only: This Authorization will expire one year from the date listed below in Section 7.

Section 6: Information regarding this Authorization

- You have the right to revoke this Authorization, in writing to the Privacy Office, at any time. The revocation is only effective after it is received and logged by the Privacy Office. Any use or disclosure made prior to a revocation is not included as part of the revocation.
- Refer to our Notice of Privacy Practices for permitted uses and disclosures of protected health information ("PHI"). You may obtain a copy of this Notice from the Privacy Office or on www.walgreens.com. Please keep a copy of this authorization for your records.
- Once PHI is disclosed to others, it may be redisclosed by them to persons or entities that are not subject to the privacy regulations, which means that the PHI may no longer be protected by regulations.
- Privacy regulations prohibit the conditioning of treatment, payment, enrollment, or eligibility for benefits on signing this Authorization.
- This Authorization must be signed and dated by the patient or signed and dated by the patient's personal representative to include a description of that person's ability to act on behalf of the patient.

Section 7: Signature

I, _____, by signing below, authorize Walgreens to use or disclose my protected health information as described above.

_____ ☐☐/☐☐/☐☐☐☐

Signature Date

Section 8: If this Authorization is signed by the patient's personal representative, please explain your authority to act (see instructions for additional information that may be required)

_____

Section 9: Mail this completed and signed form to: Walgreens Custodian of Records, 1901 East Voorhees St., MS 735, Danville, Illinois 61834; Phone: (217) 554-8949; Fax: (217) 554-8955.

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AUTHORIZATION INSTRUCTIONS

The authorization form must be completed and signed in order for the authorization to be valid as defined by the HIPAA privacy rules (45 CFR Parts 160 and 164).

Section 1: This section contains your information. This means that it is your information that would be released in accordance with your authorization.

Section 2: Provide the information of the person who you are authorizing to receive your protected health information ("PHI"). Please note that this may not always be a company. It may also be a specific person or class of persons. For example, your spouse, a specific family member, pharmacy, etc.

Section 3: This section requires that you list the information that you are authorizing us to release. This section must be specific enough for us to understand the nature of your authorization.

Section 4: The purpose for requesting the information should be provided. For example, "maintenance/management of family health care," etc.

Section 5: The authorization must include an expiration date or event. The expiration date or event must either be a specific date in the future (e.g., 01/01/2020), a specific time period (e.g., one year from the date of signature), or an event directly relevant to the individual or the purpose of the use or disclosure (upon death, 4 months after my death). The authorization cannot contain an indeterminate expiration date such as "when I revoke it," "never," N/A, upon notification or leaving the line blank.

Section 6: This section includes information regarding the authorization that you should read.

Section 7: Must be signed and dated.

Section 8: If you are signing the authorization as the legal representative of the individual listed in Section 1, and are other than the parent of the minor child whose information you are authorizing us to release, you must also submit documentation that establishes yourself as the legal representative. For example, a copy of a Power of Attorney that includes provisions to obtain medical information, etc.

If you have any questions regarding this form, you can contact Walgreens Privacy Office, 200 Wilmot Road, MS 9000, Deerfield, Illinois 60015; Phone: (847) 236-6518; Fax: (847) 236-0862.