DESIGNATION OF FAMILY MEMBERS/OTHERS TO RECEIVE MEDICAL/HEALTH INFORMATION

Walgreens may disclose on an on-going basis your medical/health information to family members or others you designate, such as a spouse, parent, adult child, or caregiver, who are involved in your care or help with insurance/payment. You understand the information disclosed to the designated family/others 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, reproductive health services, and treatment for sexually transmitted diseases.

This form is used by you to designate those family members or others who can receive such information. You will need to update this form if your circumstances/preferences change. We will continue to rely on this form until it is changed by you.

IMPORTANT NOTE: This form does not alter our ability to communicate with family members or others involved in your care that are not designated below in the event of an emergency or other circumstance where you are unavailable and, in our professional judgment, we believe it is in your best interest to do so.

Section 1: Patient's printed information

Last name, First Name: ____

DOB: ____

Street Address: ____

City, State, Zip: ____

Telephone: ____

Location you obtain most of your prescriptions: ______________________________

Section 2: Person(s) designated to receive medical/health information

Name, Relationship to Patient, Phone Number:

____

Name, Relationship to Patient, Phone Number:

____

Section 3: Signature of Patient / Personal Representative

By signing below, I confirm designation of the above family members/others to receive my medical/health information from Walgreens on an ongoing basis.

[Revised: 06/26/2023]

______________________ __________________________ ____________________
Printed Name Signature Date

Section 4: Personal Representative Attestation (if applicable)

If this Designation Form is signed by the patient's personal representative, please explain your authority to act and submit documentation that establishes you as the legal representative of the patient. For example, a copy of a Power of Attorney that includes provisions regarding health care decisions.

Explanation of Authority (e.g., Power of Attorney, Legal Guardianship, Executor of Estate, etc.):
____

Power of Attorney Representation of Incapacitation:

☐ I confirm that the patient is unable to make their own decisions and/or has been deemed incapacitated by their physician.

Section 5: Return Completed Form to the Privacy Office

Send this completed and signed form to Walgreens Privacy Office by using one of the following options:

Mail: Walgreens Privacy Office, 108 Wilmot Road, MS 3213, Deerfield, Illinois 60015

Fax: (847) 236-0862

Email: privacy.office@walgreens.com Please note that choosing to send this form through email can expose information contained in the form to security risks.