kmart pharmacy
your home for family health™

AUTHORIZATION FOR USE AND DISCLOSURE

MUST BE FILLED OUT COMPLETELY

BY SIGNING THIS FORM I AUTHORIZE KMART PHARMACY TO DISCLOSE MY PROTECTED HEALTH INFORMATION AS FOLLOWS:

Patient:_____ a/k/a:_____

Date of Birth:_____ Date of Death (if applicable):_____

Address:_____

I voluntarily authorize and permit disclosure of any and all medical records, including pharmacy prescription and expense records for the time period of: _____ through _____. NOTE: We do **NOT** have records over 10 years old)

****** If my records contain information about drug abuse/alcohol abuse, mental health, HIV/AIDS and/or sexually transmitted disease, I agree to its release, unless Initialed below. (Person signing Authorization must INITIAL those which are NOT permitted to be released)***

Drug Abuse	_____	HIV/AIDS	_____	Sexually Transmitted Disease	_____
Alcohol Abuse	_____	Mental Health	_____		

PLEASE SEND MY RECORDS TO ☑ ME, OR TO:

Name: RECORDS DEPOSITION SERVICE, INC. Complete Address: P.O. BOX 5054, SOUTHFIELD, MI 48086-5054

Phone Number: 248-357-3330 Email: REQUESTS@RECDEP.COM

The purpose of this request to release and/or disclose my protected health information is:

☑ Pending Litigation; or ☐ Insurance Submission; or ☐ Taxes; or ☐ Other (describe):_____

This Authorization will expire on the following date:_____ (If I fail to specify a date, this Authorization will automatically expire 90 days from the date of my signature).

I understand that: 1) I can revoke this Authorization at any time by giving my written revocation to Kmart Pharmacy. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization; 2) Kmart Pharmacy may NOT condition treatment, enrollment in a health plan or eligibility for benefits on whether I sign this Authorization; 3) I am authorizing disclosure of information protected under federal law; 4) This information, once disclosed, may be subject to redisclosure by the recipient and no longer be protected by state or federal law; 5) I have the right to receive a copy of the Authorization; and 6) A photocopy or facsimile of this Authorization shall have the same authority as the original and may be substituted in its place.

By my signature I certify that the information provided is true and complete. If signed by the parent of legal guardian, I certify that the patient is not [varies by individual state] married, a member of the armed forces or otherwise an emancipated minor. I understand that Kmart Pharmacy may be prohibited by law from providing certain health information and that this information will be redacted from the health information Kmart Pharmacy provides.

Signature:_____ Date:_____

Printed Name:_____

_____
Your Relationship to Patient* (MUST be Completed)

*NOTICE: ALL AUTHORIZATIONS EXECUTED BY PERSONS OTHER THAN THE PATIENT ARE REQUIRED TO BE REVIEWED BY THE LAW DEPARTMENT AT CORPORATE HEADQUARTERS. PURSUANT TO THE PROVISIONS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, 45 CFR §164.500, ET SEQ., UNLESS YOU ARE A PARENT OF AN EMANCIPATED MINOR PATIENT, **ALL PERSONS WHO EXECUTE THIS AUTHORIZATION ON BEHALF OF THE PATIENT ARE REQUIRED TO PROVIDE DOCUMENTATION WHICH LEGALLY EMPOWERS THEM WITH THE AUTHORITY TO RELEASE THE PROTECTED HEALTH INFORMATION SOUGHT.** FAILURE TO PROVIDE SUCH DOCUMENTATION WILL RESULT IN DENIAL OF THE REQUEST TO RELEASE RECORDS.

PHARMACY USE ONLY:

Verification of ID of Person Signing Authorization:	**Pharmacists Acknowledgement of ID Verification:**
☐ Driver's License ☐ Passport ☐ Military ID ☐ State ID ☐ School ID (Minors Only) ID Number & State:_____	Pharmacists Full Name:_____ Pharmacists Signature:_____ Date ID Verified:_____