Walgreens

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

Name or Company: RECORDS DEPOSITION SERVICE

Street address: PO BOX 5054

City: SOUTHFIELD | State: MI | Zip code: 48086

Telephone: (248) 357-3330

Email address: REQUESTS@RECDEP.COM

Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Caregiver ☑ Other (list): AGENT FOR ATTORNEY

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

PLEASE SEE ATTACHED SUBPOENA

Walgreens

Section 4: List the specific purpose for requesting this information

P	R	E		T	R	I	A	L		D	I	S	C	O	V	E	R	Y										

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.