WAL*MART NEIGHBORHOOD MARKET WAL*MART PHARMACY Department

Pharmacy Form
Authorization to Release Health Information

What is the Purpose of this Authorization?

This form is used by a Patient or Patient's personal representative to authorize Wal-Mart, SAM'S Club, and Neighborhood Market Pharmacies ("Pharmacy") to release health information to an individual or organization not otherwise authorized by law to receive it, as required by the Health Insurance Portability and Accountability Act ("HIPAA") and other state and federal privacy laws.

Section 1: Patient Information

Patient Name:			Date of Birth:
Address:			
City:	State:	Zip:	Phone:

Section 2: Information to be Released

(a) I authorize the release of the following health information:
- ☐ Specific Prescription(s): _____
- ☑ Medical Expense Summary (List of all prescription expenses)
- ☑ Designated Record Set (Entire medical record maintained by the Pharmacy)

(b) For the following dates of service:
- ☑ All dates of service
- ☐ From _____ to _____

(c) From the following Facilities: (list Wal-Mart, SAM'S, or Neighborhood Market, including city and state)
- ☑ All locations where I have had prescriptions filled
- ☐ Only the following locations: _____

Section 3: Recipient and Purpose

Recipient Name:	Phone: 248-357-3330 FAX: 248-357-3337
Name of Organization: RECORDS DEPOSITION SERVICE, INC.	
Street Address: P.O. BOX 5054	
City, State, Zip: SOUTHFIELD, MI 48086-5054	
The purpose of this Authorization is:	☐ At the request of the Patient / Patient's personal representative ☑ Other (state reason): FOR DISCOVERY BEFORE TRIAL

Section 4: Specific Consent

(a) I understand that my patient profile may include information related to treatment of **mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases, or communicable diseases.** I understand that the information, if any, pertaining to any of the conditions described above may be released.

Please initial the statement that applies (you must initial one): **I do X /I do not _____ authorize the release of this specific information.**

If I authorize the release of this specific information, the recipient is prohibited from redisclosing this information without written authorization by me or my personal representative, unless permitted to do so under federal or state law.

Section 4: Specific Consent, Continued

Complete this section ONLY if you indicated that you do not authorize the release of specific health information related to treatment of **mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases, or communicable diseases.**

(b) Pharmacies do not record a diagnosis for most patient prescriptions. In order for the Pharmacy to exclude information related to these conditions, I must list specific drugs and/or prescription numbers that should not be released.

	Drug Name/ Rx #	Date Range
1		
2		
3		
4		
5		
6		
7		
8		

	Drug Name/ Rx #	Date Range
9		
10		
11		
12		
13		
14		
15		
16		

Section 5: Expiration Date of Authorization

This authorization will remain in effect under the following conditions: (check one)

- ☐ Until the following date: _____, 20____
- ☐ Until the following event occurs: _____
- ☐ One Year from the date of my signature below.

Section 6: Signature

(a) I understand that signing this Authorization is voluntary. Receipt of Pharmacy services will not be conditioned upon my authorization of this disclosure.

(b) I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be redisclosed and may no longer be protected by federal or state privacy laws.

(c) I have the right to revoke this Authorization in writing at any time by filling out a Revocation Form available at any Wal-Mart Stores Inc. Pharmacy. The revocation will not apply to the extent that Wal-Mart has already released health information based on this Authorization.

_____ _____

Signature of Patient or Personal Representative | Today's Date

If you have signed this form as a legally authorized representative of the Patient, please print your name and relationship to the Patient below.

_____ _____

Name of Personal Representative (please print) | Relationship to Patient (parent, legal guardian, etc.)

☐ Please check (✓) this box if you would like to receive a copy of this form after you have signed it.