Walgreens

#3519808

The Pharmacy America Trusts®

Walgreens Custodian of Records Department, 1901 East Voorhees Street PO Box 4039, MS #735, Danville, Illinois 61834 Phone: 217.554.8949

Patient Name: _____ Phone: ( ) _____

Known a/k/a's: _____ Date of Birth: _____

Address: _____

Past Address(es): _____

Person/organization authorized to receive information from Walgreens:

Company: RECORDS DEPOSITION SERVICE, INC.

Address: PO BOX 5054, SOUTHFIELD, MI, 48086-5054 P: 248-357-3330 F: 248-357-3337

Describe the information that you are asking us to release: Prescription History.

List Specific Date Range (if Applicable) _____

List the specific purpose for requesting this information: At the patient's request.

Expiration Date: (1) One year from date of signature unless otherwise specified.

Information regarding this Authorization:

- You have the right to revoke this Authorization, in writing to Walgreens Privacy Office, at any time. The revocation is only effective after it is received and logged by Walgreens. 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.
- Our pharmacy records do not reflect the identity or existence of specific conditions, illnesses, injuries, or accidents. You acknowledge that we cannot redact on these bases and hereby consent that the released PHI may contain HIV, AIDS, STD, Communicable disease, mental health, genetic, or alcohol/substance abuse treatment information.

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

Signature: Date

Signature of Patient or Authorized Representative (State relationship)

Attach documentation of authority to sign on behalf of patient for health care.