#214449

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

All sections must be filled in completely or the authorization is NOT valid!!

AUTHORIZATION - RELEASE OF INFORMATION REQUESTED BY PATIENT

Your Name: _____

Date of Birth: _____

Street Address: _____

City, State, Zip _____

Telephone Number: _____

Person/organization authorized to receive information from Walgreens:

Name: _____

Address: _____

City, State, Zip: _____

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

_____

_____

_____

_____

List the specific purpose for requesting this information:

_____

_____

_____

_____

Expiration Date [Must include a date or specific time frame!!]:

This authorization expires [specify date or event]: _____

Information regarding this Authorization:

- You have the right to revoke this Authorization, in writing to Walgreens Custodian of Records Department, 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.
- This Authorization must be signed and dated by the patient or signed and dated by the patient's personal representative and include a description of that person's ability to act on behalf of the patient.

Signature

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

_____ _____

Signature Date

If this Authorization is signed by the patient's personal representative, please explain your authority to act and provide legal documentation:

_____

Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.

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