SPECIALTY PHARMACY

AUTHORIZATION FOR RELEASE OF RECORDS

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. parts 160 and 164)

1. Authorization:

Patient Name: _____ **Date of Birth:** _____

I authorize **Kroger Specialty Pharmacy** (Pharmacy Provider) to use and disclose the protected health information described below to:

Legal-Ease Digital Imaging Name/Relationship

_____ Name/Relationship

_____ Name/Relationship

2. Effective Period: The dates of service covered by this Authorization are:

start date _____ (MM/DD/YY) end date _____ (MM/DD/YY)

3. Extent of Authorization for the Effective Period: *(choose one)*

- ❑ I authorize the release of specific health records as indicated here: _____
- ❑ I authorize the release of my complete health record (excluding highly confidential information).
- ❑ I authorize the release of my complete health record ***including*** highly confidential information as indicated below:
  - ❑ Mental health records
  - ❑ Communicable diseases (including HIV and AIDS)
  - ❑ Alcohol/drug abuse treatment
  - ❑ Other (please specify) _____

Please indicate method of delivery: (Note: There are certain risk inherent to transmission via email. We cannot guarantee security of email transmissions):

- ❑ Email to: pat.legalease@gmail.com
- ❑ Mail to: P.O. Box 1017 Flint MI 48501-1017
- ❑ Fax to: 810-547-4030

4. What is the specific purpose for the use/disclosure of the PHI:

- ❑ At my request (patient or patient representative).

or

- ❑ List and describe <u>each</u> purpose: _____

5. I understand that I am entitled to receive a copy of this Authorization.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that revocation is only effective after it is received and logged by the pharmacy.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative and his or her relationship to patient

_____
Date

Please e-mail completed form to: compliance@krogerhealth.com

This Authorization Form expires one year from date of signature unless previously voided through written communication from patient/patient representative.
Any documentation used to verify authority as Personal Representative must be attached.