



Walgreens Privacy Office, 200 Wilmot Road, MS 9000, Deerfield, Illinois 60015
Phone: (847) 236-6518 Fax: (847) 236-0862

AUTHORIZATION – FOR RELEASE OF INFORMATION TO PERSONAL REPRESENTATIVE

This Walgreens Authorization is for use if you wish to have a spouse, parent, adult child, or caregiver have access to your medical and health information on an on-going basis to assist with your care and maintaining your information.

If you are requesting Walgreens to release information to a third-party company (for example, housing authority, insurance company, law office, etc.), do not use this form. Please complete the “Authorization – For Release of Information to Third Party” form.

Section 1: Patient’s printed information

Last name	First name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
DOB		
<input type="text"/>		
Street address		
<input type="text"/>		
City	State	Zip code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone		
<input type="text"/>		
Email address		
<input type="text"/>		

List the location you obtain most of your prescriptions: _____

Section 2: Person authorized to receive information from Walgreens

Last name	First name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
Street address		
<input type="text"/>		
City	State	Zip code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone		
<input type="text"/>		
Email address		
<input type="text"/>		

Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Caregiver ☐ Other (list): _____

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

Any and all prescription information related to medical/health services received.



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Section 4: List the specific purpose for requesting this information

To assist with the management of my care, maintenance of information, and administrative functions on my behalf relating to the services/products I receive from Walgreens.

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 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.
- 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 of 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 Privacy Office, 200 Wilmot Road, MS 9000, Deerfield, Illinois 60015; Phone: (847) 236-6518; Fax: (847) 236-0862



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AUTHORIZATION INSTRUCTIONS

The authorization form must be completed and signed in order for the authorization to be valid as defined by the HIPAA privacy rules (45 CFR Parts 160 and 164).

Section 1: This section contains your information. This means that it is your information that would be released in accordance with your authorization.

Section 2: Provide the information of the person who you are authorizing to receive your protected health information ("PHI"). Please note that this may not always be a company. It may also be a specific person or class of persons. For example, your spouse, a specific family member, pharmacy, etc.

Section 3: This section requires that you list the information that you are authorizing Walgreens to release. This section must be specific enough for Walgreens to understand the nature of your authorization.

Section 4: The purpose for requesting the information should be provided. For example, "maintenance/management of family health care," etc.

Section 5: The authorization must include an expiration date or event. The expiration date or event must either be a specific date in the future (e.g., 01/01/2020), a specific time period (e.g., one year from the date of signature), or an event directly relevant to the individual or the purpose of the use or disclosure (upon death, 4 months after my death). The authorization cannot contain an indeterminate expiration date such as "when I revoke it," "never," N/A, upon notification or leaving the line blank.

Section 6: This section includes information regarding the authorization that you should read.

Section 7: Must be signed and dated.

Section 8: If you are signing the authorization as the legal representative of the individual listed in Section 1, and are other than the parent of the minor child whose information you are authorizing Walgreens to release, you must also submit documentation that establishes yourself as the legal representative. For example, a copy of a Power of Attorney that includes provisions to obtain medical information, etc.

If you have any questions regarding this form, you can contact Walgreens Privacy Office, 200 Wilmot Road, MS 9000, Deerfield, Illinois 60015; Phone: (847) 236-6518; Fax: (847) 236-0862.