Pharmacy and Health-Related Services:
Patient Profile Request Authorization Form

This form should be used by the patient or his/her Personal Representative to request printouts of the patient's prescription history. A Personal Representative is someone who has legal authority to make healthcare decisions on behalf of the patient. Other requests for records must be sent to the company's Privacy Representative.

The printout may be given to an immediate family member, if authorized in writing on this form by the patient or his/her Personal Representative. The individual receiving the printout may be required to present satisfactory identification. Customer requests to release records to other individuals or organizations must be sent to the company's Privacy Representative. For more information, ask the Pharmacist.

A separate authorization form is required for each patient.

Please fill out the following information, and complete 1 and 2 below:

Name of Patient/Individual: _____ Date of Birth: _____

Address: _____ Daytime Phone: _____

Store Name: _____ Store Address:_____

I authorize the use or disclosure of my health information, as described below.

1. <u>Please describe the health information to be disclosed</u>:

☐ Prescription profile for time period _____

☐ Other (please describe): _____

I understand that this health information may include HIV-related information and/or information relating to substance abuse treatment and/or mental health diagnoses and treatment and that by signing this form, I am authorizing such information to be disclosed.

2. <u>Please complete the following, as applicable:</u>

I authorize the pharmacy identified above to disclose the information described above to:

- ☐ Myself
- ☐ The following family member: _____

<u>Expiration:</u>

This Authorization will expire sixty (60) days after the date signed, unless otherwise noted.

Please continue on the other side

This information is being disclosed at my request and for my own purposes. I understand that, if the person or entity that receives the information is not a health care provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above may be redisclosed to others and no longer protected by the Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand that I may revoke this Authorization in writing at any time, except to the extent that the Ahold USA pharmacy identified above has already taken action in reliance on this Authorization, by submitting a written statement of revocation to the Privacy Representative.

I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment or eligibility for benefits.

By signing below, I acknowledge that I have read and understand this Authorization form.

_____ _____

Signature of Patient or Patient's Personal Representative

Date

If signed by the Patient's Personal Representative, please print name and describe relationship to patient or other authority to act:

_____ _____

Name

Relationship to Patient

☐ *Check here if you would like a copy of this Authorization form mailed to you*

FOR PHARMACY USE ONLY:

Date information prepared: _____ Prepared by: _____

Person receiving profiles: _____ Signature: _____

(print name of customer) (customer receiving profile)

Person disclosing profile/date: _____ Identification presented: _____