Authorization to Release Private Health Information

Legal

HIPAA Team

702 SW 8th Street
Bentonville, AR 72716-0215
Phone 479.273.4505
Fax 479.204.9655
rxlegal@walmartlegal.com

Section 1: Patient Information

Patient Name:			Date of Birth:
Address:			
City:	State:	Zip:	Phone:

Section 2: Requestor and Purpose **(If to be released to patient check here ☐ and continue with Section 3)**

Individual or Entity:		Person Receiving Information:	
Address:			
City:	State:	Zip:	Phone:

Purpose of Release: ☐ Patient Request ☐ Legal/Attorney Letter ☐ Insurance ☐ Housing

Section 3: Information to be Released (Check All That Apply)

I authorize Walmart to release of the following health information:
☐ Medical Expenses Summary (List of all prescriptions with expense information)
☐ Designated Record Set (Entire medical record maintained by the pharmacy)
☐ Specific Prescription(s): ______________________________
☐ One Line Summary (total number of prescriptions and out-of-pocket expenses)

For the following dates of service:
☐ All dates of service ☐ From ____________________ to ____________________

From the following facilities:
☐ All locations where I have had prescriptions filled
☐ Only the following location(s) (include city and state): ______________________________

Section 4: Expiration Date or Event

This authorization will remain in effect
☐ Until the following date: ______________________________
☐ Until the following event occurs: ______________________________
☐ Until one year from the date of my signature below.

Section 5: Understandings

(a) I understand that signing this authorization is voluntary. Receipt of pharmacy services will not be conditioned upon my authorization of this disclosure. (45 C.F.R. 164.508(c)(2)(ii))

(b) I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be redisclosed and may no longer be protected by federal or state privacy laws. (45 C.F.R. 164.508(c)(2)(iii))

(c) I have the right to revoke this authorization in writing at any time by notifying the Walmart Legal Department. The revocation will not apply to the extent that (i) Walmart has already released health information based on this authorization or (ii) this authorization was obtained as a condition to the patient obtaining insurance or for an insurer to contest a claim. (45 C.F.R. 164.508(c)(2)(i))

(d) I understand that by signing below I authorize the release of records that may include: HIV/AIDS related information and or records; Mental Health Information and or records; Drug/Alcohol Diagnosis and Treatment Information; Pregnancy and Family Planning Information; Sexually Transmitted Disease Information.

Section 6: Signature and Date

______________________________ ______________________________
Signature of Patient or Personal Representative Date

If you have signed this as a legally authorized representative of the patient, please print your name and relationship to the patient below. If your relationship is anything other than parent of a minor, please include documentation of your authority to sign for the patient's records.

______________________________ ______________________________
Name of Personal Representative (please print) **Relationship to Patient (parent, guardian, etc.)**