Authorization to Release Protected Health Information
(Authorized Representative)

I authorize the release of ☐ Pharmacy Information ☐ Vision Center/Optical ☐ Care Clinic information from the following facility: (include city and state):

_____

What is the Purpose of this Request?
This request allows you to authorize others (e.g. family, friends) to access your Protected Health Information ("PHI"). You can authorize the release of your PHI maintained by Walmart and Sam's Club Pharmacies, Vision Centers/Opticals or Care Clinics (collectively "Walmart"). This Authorization will only apply to the health care service indicated above. You must fill out an Authorization for each Pharmacy, Vision Center/Optical or Care Clinic location from which you wish to release your PHI. If information from multiple stores is requested, then only the previous 2 years of records may be provided at store level. Vision Center/Optical and Care Clinic information can only be provided for the location where service was provided.

Section 1: Patient Information

Patient Name (last, first, middle initial):			Date of Birth (mm/dd/yyyy):
Address:			
City:	State:	Zip Code:	Phone Number:

Section 2: Requestor

Individual or Entity:		Person Receiving Information:	
Address:			
City:	State:	Zip Code:	Phone/Fax Number:

Section 3: Information to be Released (Check all that apply)

I authorize Walmart to release the following Protected Health Information (PHI):
☐ Medical Expense Summary (list of all prescriptions with expense information)
☐ Designated Record Set (entire medical record maintained by the Pharmacy or Care Clinic)
☐ Dispensing Records (entire record maintained by the Vision Center or Optical)
☐ Other (please describe):
For the following dates of service:
☐ All dates of service **or** From _____ to _____

Section 4: Expiration Date of Authorization

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

Section 5: Understandings (you must check all of the following)

☐ I understand that signing this authorization is voluntary. Walmart will not deny Pharmacy, Vision Center/Optical or Care Clinic services to me if I refuse to sign this authorization.

☐ 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 re-disclosed and my no longer be protected by federal or state privacy laws.

☐ I have the right to revoke this authorization at any time by completing a "Revocation of Authorization to Release Protected Health Information" form. The revocation will not apply if (i) Walmart released PHI prior to receiving the revocation; or (ii) this authorization was obtained as a condition to the patient obtaining insurance

☐ I understand by signing below I authorize the release of records that may include: HIV/AIDS related information; mental health information; drug/alcohol diagnosis and treatment information; pregnancy and family planning information; sexually transmitted disease information

Section 6: Signature and Date

_____	_____	_____
Name of Patient or Personal Representative (please print)	Signature of Patient or Personal Representative	Date

If you have signed this form as a legally authorized representative of the patient, please identify your relationship to the patient below. (parent, guardian, etc. _____

For Office Use Only

Store/Club Number:_____
Please initial to verify that you called the Patient who confirmed valid authorization: _____