Authorization to Release Protected Health Information

I authorize the release of ☐ Pharmacy ☐ 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, third parties) 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/Optical Centers or Care Clinics (collectively "Walmart"). This Authorization will only apply to the health care service area 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

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: Recipient of PHI

Individual or Entity 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) (check all that apply):
☐ 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 _____
For the following purposes:
☐ At the request of the patient
☐ Other (please describe):

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

- 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 may no longer be protected by federal or state privacy laws.
- I have the right to revoke this Authorization at any time in writing, by completing a "Revocation of Authorization to Release Protected Health Information" form. The revocation will not apply: (i) to PHI Walmart released in reliance on this Authorization, prior to receiving the revocation; or (ii) if this Authorization was obtained as a condition to the patient obtaining insurance coverage.
- I understand that records released pursuant to this Authorization 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 indicate your relationship/authority to act on behalf of the patient (parent, guardian, etc.): _____

For Office Use Only

Store/Club Number:_____

Please initial to verify that you (1) confirmed the form was signed and all sections completed and (2) provided a signed copy of the form to the patient/personal representative: _____

See POM/VCOG/COM 1610 for more information.