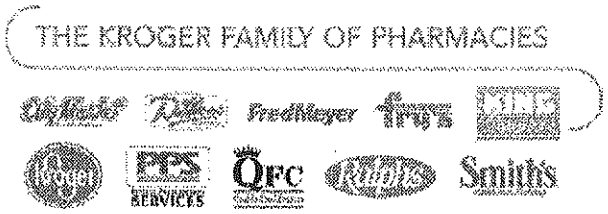

To Whom It May Concern:

I am in receipt of your authorization and records request. However the authorization does not appear to be in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated pursuant thereto. Specifically, the authorization is deficient in that it does not contain following item(s): Please refer to

1. A description of the information to be used or disclosed
2. The identity of the person or entity authorized to make the requested use or disclosure
3. The identity of the person or entity to whom the covered entity may make the requested use or disclosure
4. A description of the purpose of the requested use or disclosure
5. An expiration date or event that relates to the individual or the purpose of the use or disclosure
6. The signature of the individual or the individual's personal representative and the date
7. A statement that the individual may revoke the authorization
8. A statement of how the individual may revoke the authorization
9. A statement that any revocation does not apply to previous disclosures made by the covered entity in reliance on the authorization (exception to the right to revoke)
10. A statement that the covered entity may not condition treatment on whether the individual signs the authorization
11. A statement that the information disclosed pursuant to the authorization is subject to re-disclosure by the recipient of the information and no longer protected by HIPAA

For your convenience I am enclosing Kroger's authorization form. Please either use the Kroger authorization form or provide us with an otherwise HIPAA compliant authorization. Upon receipt, we will provide the requested records. Should you have any questions with respect to this matter, please do not hesitate to contact me. I can be reached at (513) 698-1884.

Sincerely,

Paula Hammer-McGuire
Kroger Privacy Office

KROGER PHARMACY AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I _____ [Name] hereby authorize the use and/or disclosure of my protected health information ("PHI") as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:
_____

2. Specific person/organization (or class of persons) authorized to receive and use the information:
_____

3. Specific description of the information:
_____
_____

4. Specific purpose for the use and/or disclosure of the PHI (list and describe each purpose):
_____
_____

5. I understand that I may revoke this Authorization at any time by notifying Kroger in writing at the Kroger Privacy Office, 1014 Vine St., Cincinnati, OH 45202-1100. I understand that the revocation is only effective after it is received and logged by Kroger. I also understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from the pharmacy.

7. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.

8. I understand that I am entitled to receive a copy of this authorization.

9. This Authorization expires _____ [date or event].

_____ _____
Signature of Customer or Personal Representative Date

Address _____ _____
Telephone (optional)

_____ _____
E-Mail (optional)

Verification of Identity: _____ Known Individual
_____ Driver's License
_____ Other ID, specify _____

If signed by the patient's personal representative, the representative warrants that he or she has authority to sign this form on the basis of (attach a copy of any documentation used to verify authority):

Division: _____ Store Number: _____
Received by: _____