AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By my signature hereon, I authorize Supervalu, Inc., or any of its subsidiary companies or pharmacies, to release my protected health information as identified and in the manner and/or to the person(s) indicated below.

PHARMACY LOCATION:_____

PATIENT'S NAME:_____
(First) (M.I.) (Last)

PATIENT'S ADDRESS:_____

PATIENT'S DATE OF BIRTH:_____/_____/_____

PURPOSE OF DISCLOSURE:

- ☐ At the request of the patient.
- ☐ Other (provide explanation):_____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____

I AUTHORIZE THE FOLLOWING TO **REQUEST** PROTECTED HEALTH INFORMATION ON MY BEHALF:

_____

I AUTHORIZE THE FOLLOWING TO **RECEIVE** THE PROTECTED HEALTH INFORMATION INDICATED ABOVE:

_____

*THIS AUTHORIZATION SHALL EXPIRE ON THE FOLLOWING DATE OR AT THE CONCLUSION OF THE FOLLOWING EVENT: **mm**_____**dd**_____**yyyy**_____(THIS AREA MUST BE FILLED IN)

I understand that my Authorization, or refusal to provide additional Authorization(s), does not affect my ability to obtain treatment from the pharmacy. I may revoke this Authorization in writing at any time by sending a letter to the pharmacy or by completing the pharmacy's Authorization Revocation Form, except to the extent that the pharmacy has taken action in reliance on this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA privacy regulations.

_____ I hereby represent and certify by my initials here and signature below that I am the patient identified above and that I give this Authorization of my own free will, am competent by law to give such Authorization, and will hold Albertsons and its affiliates and subsidiaries harmless from liability for their compliance with the provisions of this Authorization.

_____ I hereby represent and certify by my initials here and signature below that I am not the patient identified above, but provide this Authorization as a legal guardian, agent, representative, or executor of the patient or his/her estate. I represent by my signature below that I am legally or otherwise authorized to provide such Authorization on behalf of the patient. **(Note: Proof evidencing legal authority is required.)**

DATED:_____ SIGNED:_____

PRINTED:_____

Patient or Authorized Representative