# Authorization to Release Protected Health Information

I authorize the release of: □ Pharmacy Record ☑ Vision Center/Optical Record □ Walmart/Sam's Club Optometrist Record
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/Opticals, or Optometrists. 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 Optometrist 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: Legal-Ease Digital Imaging LLC | | | |
|---|---|---|---|
| Address: 2496 Meadowcroft Dr | | | |
| City: Burton | State: Michigan | Zip Code: 48519 | Phone/Fax Number: 855-534-4003 / 810-547-4030 |

**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)
☑ Dispensing Records (entire record maintained by the Vision Center or Optical)
□ Walmart/Sam's Club Optometrist Records
□ 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): Litigation

**Section 4: Expiration Date of Authorization**

| This authorization will remain in effect<br>□ 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 Optometrist 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; reproductive health information, including but not limited to 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 Store/Club 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 1610 for more information.*