



## HIPAA FORM 104

### **AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

**This authorization form must be filled out completely.**

Name of Customer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Store Name: \_\_\_\_\_

Store Address: \_\_\_\_\_

I authorize the use or disclosure of my protected health information (PHI), as described below.

☐ Prescription information for the following timeframe: \_\_\_\_\_

**Prescription records may include medications related to the treatment of HIV/AIDS, substance abuse, psychiatric or mental health, and reproductive health care. If you prefer to exclude these records from this request, please indicate below which records should be excluded:**

- ☐ HIV/AIDS (check box to exclude)
- ☐ Substance abuse (check box to exclude)
- ☐ Psychiatric or Mental health (check box to exclude)
- ☐ Reproductive health care (check box to exclude)

☐ Lab values and any other information related to diabetes or diabetic-related conditions

☐ Other (please describe): \_\_\_\_\_

#### **Check and complete one or both of the following:**

1. ☐ I authorize the pharmacy(ies) identified above to **disclose** the information described above to **me**:
2. ☐ I authorize the pharmacy(ies) identified above to **disclose** the information described above to the **person or organization** named below:

\_\_\_\_\_

and I authorize that person or organization to use the information for the following purpose(s):

\_\_\_\_\_

3. ☐ I authorize the pharmacy(ies) identified above to **request** the information described above from the **person or organization** named below:

\_\_\_\_\_

and I authorize the pharmacy(ies) to use the information for the following purpose(s):

\_\_\_\_\_

#### **Expiration:**

This Authorization will expire sixty (60) days after the date signed or on the following date: \_\_\_\_\_.

**IMPORTANT INFORMATION  
PLEASE READ CAREFULLY!**

I understand that I have a legal right to revoke this authorization only by writing to the HIPAA Privacy Officer at the following address:

HIPAA Privacy Officer  
c/o Ahold Delhaize USA Services, LLC Legal Department  
P.O. Box 1000, Mail Sort 9805  
Portland, ME 04104

I understand that the revocation will be effective as of the date it is received by the HIPAA Privacy Officer. I also understand that any attempt to revoke this authorization will not be effective to the extent the Pharmacy has already relied on it to use or disclose my protected health information. I understand that my attempt to revoke this authorization will not be effective if it was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. I understand that further information regarding my ability to revoke this authorization is contained in the Pharmacy's Notice of Privacy Practices. The Pharmacy will not condition my treatment, payment or eligibility for any benefit or services on whether I provide an authorization for the use or disclosure of protected health information. I understand that protected health information disclosed pursuant to this authorization may be subject to re-disclosure and that re-disclosure by the recipient may no longer be protected by state or federal law.

By signing below, I acknowledge that I have read and understand this Authorization form.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

If signed by the Patient's Representative, please print name and describe relationship to the patient or other authority to act:

\_\_\_\_\_  
Name of Patient Representative

\_\_\_\_\_  
Relationship to Patient

For Pharmacy Use Only

Pharmacy #: \_\_\_\_\_

Date request processed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Processed by: \_\_\_\_\_

Signature: \_\_\_\_\_

Identification/documentation presented by requesting party: \_\_\_\_\_