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 Date of Birth

Address _____ _____
Telephone (optional)

_____