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:
MINUTE MAN SERVICES 3318 N. MAIN, ROYAL OAK, MI 48073_______

3. Specific description of the information:

____
____

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

____
LEGAL REVIEW ______________________________________

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: ______________________

THE KROGER CO.
RIGHT TO REQUEST CERTIFICATION

Individual Requesting Medical Records: ____________________

Patient Records Requested for: ____________________ Date of Birth: ____________________

Requestors Relationship to Decedent: ____________________

I, ____________________, certify that that under applicable state law I qualify as the personal representative of the patient as defined by HIPAA in 45 CFR 164.502(g), and that I am authorized to act on behalf of the above-listed patient with respect to protected health information.

Signature: ____________________ Date: ____________________

Printed Name: ____________________