Walgreens

#692670

The Pharmacy America Trusts®

Walgreens Custodian of Records Department, 1901 East Voorhees Street PO Box 4039, MS #735, Danville, Illinois 61834 Phone: 217.554.8949

Patient Name: _____ Phone: ( ) _____

Known a/k/a's: _____ Date of Birth: _____

Address: _____

Past Address(es): _____

Person/organization authorized to receive information from Walgreens:

Company: GEMINI DUPLICATION

Address: 6020 West Oaks Blvd, Ste310 Rocklin, CA 95765

Describe the information that you are asking us to release: Prescription History.

List Specific Date Range (if Applicable) _____

List the specific purpose for requesting this information: At the patient's request.

Expiration Date: (1) One year from date of signature unless otherwise specified.

Information regarding this Authorization:

- You have the right to revoke this Authorization, in writing to Walgreens Privacy Office, at any time. The revocation is only effective after it is received and logged by Walgreens. Any use or disclosure made prior to a revocation is not included as part of
- Refer to our Notice of Privacy Practices for permitted uses and disclosures of protected health information ("PHI"). You may obtain a copy of this Notice from the Privacy Office or on www.walgreens.com. Please keep a copy of this authorization for your
- Once PHI is disclosed to others, it may be redisclosed by them to persons or entities that are not subject to the privacy regulations, which means that the PHI may no longer be protected by regulations.
- Privacy regulations prohibit the conditioning of treatment, payment, enrollment, or eligibility for benefits on signing this Authorization.
- This Authorization must be signed and dated by the patient or signed and dated by the patient's personal representative to include a description of that person's ability to act on behalf of the patient and proper documentation.

Signature:

I, _____ by signing below, authorize Walgreens to use or disclose my protected health information as described above.

_____

Signature of Patient or Authorized Representative (State relationship) Date

Certification of Satisfactory Assurances

As required by the Standards for Privacy of Individually Identifiable Health Information ("Privacy Regulations") promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this certification provides satisfactory assurances that appropriate steps have been taken to notify and/or otherwise protect the privacy of the individual who is the subject of the protected health information that is being requested. ***PLEASE COMPLETE EITHER THE NOTICE SECTION OR THE PROTECTIVE ORDER SECTION, AND SIGN AND DATE AT THE BOTTOM. IN LIEU OF A CERTIFICATION OF SATISFACTORY ASSURANCES, YOU MAY ATTACH A WAIVER OF THE OBJECTION PERIOD(S) SIGNED BY THE PATIENT'S ATTORNEY AND RECORDS WILL BE SENT.***

_____ **Notice**

In compliance with 45 C.F.R.§ 164.512(e)(1), I hereby certify that I have made a good faith attempt to provide written notice to _____, DOB _____, (the 'individual'), whose protected health information I am requesting, by mailing a notice to the individual or the individual's attorney at:

Street Address: _____
City, State, Zip: _____

A copy of such written notice is attached to this Certification.

I certify that the notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal. **Further, I certify that the time for the individual to raise objections to the court or administrative tribunal has elapsed and either:** (1) no objections were filed; or (2) all objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

OR

_____**Qualified Protective Order**

In compliance with 45 C.F.R. § 164.512(e)(1), I hereby certify that:

_____ The parties to the dispute giving arise to this request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or

_____ I requested a qualified protective order from the court or administrative tribunal on _____.

A copy of the qualified protective order or my request for such order is attached to this Certification.

_____ _____
Name Date

_____ _____
Signature Company