

PATHMARK STORES, INC.
**AUTHORIZATION TO RELEASE PRESCRIPTION RECORD TO SOMEONE
OTHER THAN PATIENT OR PARENT/GUARDIAN OF MINOR**

STORE #: _____

DATE: _____

NAME OF PATIENT: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

DATE RANGE FOR REQUESTED RECORDS/RECEIPTS:

STARTING : (MONTH / YEAR) _____ ENDING : (MONTH / YEAR) _____

I hereby request and authorize Pathmark Stores, Inc. to release my prescription records/receipts to:

(Full Name of Party to Receive Records) ADDRESS: _____

CITY, STATE, ZIP: _____

I understand that I may revoke this Authorization at any time, except to the extent that Pathmark Stores, Inc. has taken action in reliance on the Authorization. My revocation of this Authorization will only be effective if I submit my revocation to Pathmark Stores, Inc. in writing.

I understand that I am not required to sign this Authorization, and that my refusal to sign will not affect my ability to obtain Pharmaceutical Services at Pathmark Stores, Inc. However, I also understand that failure to sign this Authorization will prevent Pathmark Stores, Inc. from releasing my prescription records/receipts to the Party named above.

I understand that the Party named above could redisclose the information contained in my prescription profile and that it may no longer be protected by the federal privacy regulations.

I would like this Authorization to expire on _____
(Date or Specific Timeframe).

Pathmark Stores, Inc. may disclose my prescription records/receipts to the Party named above pursuant to this request.

Signature of Patient or Patient's Representative

Print Name

Date

(Description of Representative's Authority To Act for Patient)

PLEASE ALLOW FOUR TO SIX WEEKS FOR DELIVERY OF ALL RECORDS OLDER THAN 16 MONTHS.

(To Be Filled Out When Records Are Picked Up)

PARTY RECEIVING RECORDS VERIFICATION: _____ DATE: _____

PRIOR TO RELEASING ANY PATIENT PRESCRIPTION RECORDS/RECEIPTS, THE IDENTITY OF THE PARTY RECEIVING THE RECORDS MUST BE VERIFIED.

I _____ HAVE RECEIVED THE ABOVE REQUESTED PRESCRIPTION RECORDS/RECEIPTS
(PRINT NAME)

SIGNATURE: _____

TYPE OF ID: _____
(Driver's Licence or Other Photo ID)

NAME: _____

VERIFIED BY: _____

ADDRESS: _____

PHONE #: _____

CITY, STATE, ZIP: _____

