



## Authorization for Release of Personal Health Information

I hereby authorize the use or disclosure of my individually identifiable health information, either verbally or in writing, from the pharmacy or Busch's as described below.

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Name of persons/organizations authorized to receive the information: \_\_\_\_\_

Specific description of information to be used or disclosed: \_\_\_\_\_

- Check if your authorization includes disclosure of PHI regarding testing or treatment for AIDS, ARC or HIV
- Check if your authorization includes disclosure of PHI regarding treatment for counseling and mental health

Specific purpose of the disclosure: \_\_\_\_\_

This authorization will expire on \_\_\_\_\_ **or** when the following occurs \_\_\_\_\_

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the pharmacy or Privacy Officer. The revocation will not be effective to the extent that Busch's has already disclosed the information. I am not required to sign this form to receive my health care benefits (enrollment, eligibility, treatment or payment). I understand that the pharmacy may not condition its services based on whether I sign this authorization. I understand that I have the right to receive a copy of this authorization after it is signed. I understand that I may refuse to sign this authorization. I understand that the persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my PHI may no longer be protected under state and federal privacy laws.

\_\_\_\_\_  
Signature of Individual or Individual's Representative  
Form MUST be completed before signing

\_\_\_\_\_  
Date

If signed by a person other than the individual, please check the relationship and authority to do so:

- Parent of minor child       Power of attorney       Legal guardian
- Member is mentally competent, but physically unable to sign and has verbally asked or physically demonstrated a request for the above signer to sign on the individual's behalf.
- Personal representative or Executer for deceased person       Other

Give to the pharmacist, fax to 734-214-8252 or mail to: Privacy Officer at Busch's; 565 E. Michigan Ave; Saline, MI 48176