WEGMANS PHARMACY
Authorization for Disclosure of Medical Information

I, _____, hereby authorize and request Wegmans Pharmacy
[Print Your Name]
to disclose my individually identifiable health information to: [List name and address of person to whom information may be disclosed]
Name: _____
Address (Street, City, State, Zip): _____
_____

Such authorized disclosures by Wegmans Pharmacy may include all of my individually identifiable health information that Wegmans Pharmacy maintains, creates, or otherwise obtains for purposes of filling my prescriptions or providing me with pharmacy services. This information may include, but is not limited to, my name, address, my physician's name, medical condition and other prescription information. I further understand that the information disclosed by Wegmans Pharmacy pursuant to this authorization may be used and disclosed by the recipient and may no longer be protected by the Federal Privacy Regulation (45 C.F.R. pt 164).

I understand and agree that this authorization shall expire **two years** from the date of my signing this authorization or two years from the date this authorization is received by Wegmans Pharmacy, whichever is sooner. If I wish to have the authorization expire at an earlier date, I can do so in the lines below. The following are criteria or limitations that I wish to make regarding this authorization: _____
_____.

I understand and acknowledge that Wegmans Pharmacy may not condition treatment, payment, or enrollment for benefits on whether I sign this authorization, unless Wegmans Pharmacy's treatment of me is related to a research project for which my information is required or Wegmans Pharmacy's provision of health care is for the purpose of creating protected health information for a third party to whom the information will be disclosed.

I understand that I have the right to revoke this authorization, at any time, by sending my written revocation to: Wegmans Chief Privacy Officer, P.O. Box 30844, Rochester, New York 14603-0844. However, the revocation will not apply to the extent that Wegmans Pharmacy has taken action in reliance upon this authorization.

_____ _____
Patient's Signature Date

_____
Patient's Printed Name

_____
Patient's Date of Birth

Pharmacy: Send by Intercompany Mail to Pharmacy Office

Customers can either give this to Pharmacy or mail this authorization to:
Wegmans Food Markets, Inc.
Pharmacy Office
1500 Brooks Avenue, P.O. Box 30844
Rochester, New York 14603-0844