Completed Authorizations may be fulfilled by the pharmacy or may be faxed, emailed, or mailed to:
Giant Eagle Privacy Office, Attn: Profiles Coordinator, 101 Kappa Drive, Pittsburgh, PA 15238
412-967-4966 (phone); 412-968-9367 (fax); privacyoffice@gianteagle.com

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By my signature below, I certify that I am the subject patient or authorized patient representative and hereby authorize Giant Eagle, Inc., or any of its subsidiary companies or pharmacies, to use and/or disclose the protected health information described and in the manner and/or to the person(s) indicated below. ***(Note: All elements marked with an asterisk (*) are required to be completed.)***

*PATIENT'S NAME: Enter text here

*PATIENT'S ADDRESS: Enter text here

DELIVERY PREFERENCE: ☐ U.S. Mail ☐ Email ☐ Facsimile to: Enter text here

MAIL TO/EMAIL ADDRESS (if different from address on file): Enter text here

(Note: "Mail to" addresses that are different from the patient's current address on file require photo identification to be verified.)

*PATIENT'S DATE OF BIRTH: PHOTO IDENTIFICATION NO. Enter text here

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*PURPOSE OF THE DISCLOSURE: ☐ For patient's own use ☐ Other **(Please explain)**: Enter text here

*DESCRIPTION OF INFORMATION REQUESTED: Enter text here

I AUTHORIZE THE FOLLOWING TO **REQUEST** MY PROTECTED HEALTH INFORMATION ON MY BEHALF: Enter text here

I AUTHORIZE THE FOLLOWING TO **RECEIVE** MY PROTECTED HEALTH INFORMATION INDICATED ABOVE: Enter text here

*THIS AUTHORIZATION SHALL EXPIRE ON THE FOLLOWING DATE OR AT THE CONCLUSION OF THE FOLLOWING EVENT. **(One or both may be completed.)**

☐ Date: ☐ Event: Enter text here

I understand that: The information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol, drug or other abuse. I authorize the release or disclosure of this type of information.
My Authorization, or refusal to provide additional Authorization, does not affect my ability to obtain treatment from the pharmacy. I may revoke this Authorization in writing at any time by sending a letter to the pharmacy or by completing the pharmacy's Authorization Revocation Form, except to the extent that the pharmacy has taken action in reliance on this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA privacy regulations. ***(*Please initial next to the appropriate paragraph and sign and date below.)***

Enter text here I hereby represent and certify by my initials here and my signature below that I am the patient identified above and that I give this Authorization of my own free will, am competent by law to give such Authorization, and will hold Giant Eagle and its affiliates and subsidiaries harmless from liability for their compliance with the provisions of this Authorization.

OR

Enter text here I hereby represent and certify by my initials here and my signature below that I am not the patient identified above, but provide this Authorization as a legal guardian, agent, representative, or executor of the patient or his/her estate. I represent by my signature below that I am legally or otherwise authorized to provide such Authorization on behalf of the patient. ***(Note: Proof evidencing legal authority is required.)***

*DATED:

*SIGNED (by typing your name and checking the box below, you are signing electronically and attesting to the accuracy and truthfulness of the information provided in this Authorization):

Enter text here

☐ Patient or ☐ Authorized Representative