



PATIENT REQUESTING DISCLOSURE

Name: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_

I hereby authorize Goodson Drug Company to disclose my Patient Prescription Record (PPR), reflecting information regarding my pharmacy services as set forth below:

1. My Patient Prescription Record may be disclosed to the following person(s):  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_
2. I understand that I am signing this Authorization of my own free will and that this authorization will not affect my ability to obtain treatment from the pharmacy. I hereby state that this disclosure is at my request. A photocopy or facsimile of this signed authorization is as valid as the original and will be accepted.
3. I understand that if the person or entity that receives my PPR is not required to comply with the federal privacy regulations, the information described above may be redisclosed and would no longer be protected by those regulations.
4. This Authorization will expire 6 months from the dated signature on this authorization unless otherwise indicated here.

\_\_\_\_\_  
Signature of Patient or Personal Representative\*

\_\_\_\_\_  
Date

\*To the patient's personal representative, explain your authority to act on behalf of the patient:

\_\_\_\_\_  
\_\_\_\_\_

**Goodson Drug Company**  
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