COSTCO HEALTH CENTERS AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please provide the information below. We cannot respond to your request without this information.

Patient Name:_____ Date of Birth: _____

Costco membership # (if applicable):_____ Relationship: _____

Patient Address: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth below:

☒ **Costco Pharmacy** ☐ **Costco Optical** ☐ **Costco Hearing Aid Center**

(Check the applicable Costco Health Center)

Name and address of person or entity to whom information may be released:

Send to patient directly

Send to patient directly

Send to patient directly

Send to patient directly

Reason for disclosure: ☒ Request of individual ☐ Other: _____

Specific information to be released: ☒ Entire Medical Record

☐ Medical Records from (date) _____ to (date) _____

Understandings:

- This authorization may be revoked in writing at any time, except to the extent that disclosure of information has already occurred prior to the receipt of revocation.
- Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If no expiration date, event or condition is noted, this authorization will expire one (1) year from the date of signing.
- This authorization may include disclosure of information relating to alcohol/drug abuse, mental health treatment , STD or HIV/AIDS related treatment only if I place my initial on the appropriate line below:

  _X_ Alcohol/Drug Treatment _x_ Mental Health Treatment

  _____ STD Treatment _____ HIV/AIDS
- I understand that a photocopy of this authorization shall be considered as effective and valid as the original.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.
- I understand that I am signing this authorization voluntarily and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my authorization of this disclosure.

Patient Signature: _____ Date: _____

Personal Representative Signature*: _____ Date: _____

**If you are making this request on behalf of another individual, evidence of your personal representative status must be provided to the Costco Health Centers.*

Costco Wholesale Corporation
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Phone 425-313-8347 • Fax 425-313-2822