Attorney Authorization

I authorize Rite Aid to disclose medical information at my request that it maintains to- RecordTrak 651 Allendale Road P.O. Box 61591 King of Prussia, PA 19406 for usein my legal representation. This Authorization includes any and all information Rite Aid may have about me, including, but not limited to, information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy data and EKG's.

I understand that the potential exists for my information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and to be no longer protected.

This authorization will expire six months from the date of my signature as indicated below.

I understand that Rite Aid may not disclose my information as requested above without my signature on this Authorization and that my signing or refusing to sign this Authorization will not affect my ability to receive treatment, payment or health care operations from Rite Aid.

I understand that I have the right to revoke this authorization in writing at any time prior to the expiration date by sending my written revocation to Privacy Office, Rite Aid Corporation, P. O. Box 3165, Harrisburg, PA 17105. Any actions based on this Authorization that Rite Aid may have taken prior to their receiving notice of my revocation will be considered validly authorized.

Patient _____ Parent or Guardian _____
Power of Attorney _____ Court Appointed _____

Date_____ Signature _____
Printed Name_____
Social Security Number _____
Date of Birth _____