Attorney Authorization

I authorize Rite Aid to disclose medical information at my request that it maintains to-
RECORDS DEPOSITION SERVICE, INC. (name of law firm) for use in 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 information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law.

This authorization will expire one year 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 Rite Aid, Legal Department, 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's Name _____
Patient's Date of Birth _____
Patient's Social Security Number_____

Date_____ Signature _____
Printed Name_____

IF PERSON OTHER THAN THE PATIENT SIGNED THIS AUTHORIZATION, PLEASE INDICATE RELATIONSHIP BELOW AND PROVIDE PROPER DOCUMENTATION:

Power of Attorney _____ Parent or Guardian _____

Court Appointed _____ Other (Please Explain) _____

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