BAYSHORE PHARMACY
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PATIENT INFORMATION DISCLOSURE REQUEST TO RECEIVE MEDICAL EXPENSE REPORT

Name: _____

Address: _____

City, State, Zip: _____

Date of Birth _____

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

1. My Patient Prescription Record (PPR), may be disclosed to the following person(s):
Name: _____
Address: _____
City, State, Zip: _____

2. I understand that I may revoke this authorization at any time by writing to Bayshore Pharmacy, 2 Bayshore Plz, Atlantic Highlands NJ 07716, except to the extent that Bayshore Pharmacy has taken action in reliance on this authorization.

3. 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.

4. 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.

5. This Authorization will expire 6 months from the dated signature on this authorization.

_____ _____
Signature of Patient Date

*To the patient's personal representative, explain your authority to act on behalf of the patient to receive medical expense report.