Attorney Authorization

I authorize Rite Aid to disclose medical information that it maintains to - _____ for use in my legal representation.

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.

I understand that I have the right to receive a copy of this Authorization.

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

Date_____ Signature _____