Release of Information
(Informed Consent*)

SHOPKO®

LOCATION USE ONLY

Date of Request: ____________ Time of Request: ________

IF PRIVACY OFFICE MUST PROCESS REQUEST, FAX TO 920-429-4444

Section A: Patient Information Please print clearly.

LAST NAME FIRST NAME MI

ADDRESS CITY STATE ZIP

DATE OF BIRTH / / GENDER (M/F) PHONE NUMBER

Section B: Records to be Released

I request the release of my complete healthcare record in the designated record set as checked below (subject to any checked exclusion[s]):

Pharmacy
- ☐ Medical expense summary (Shopko Pharmacy)

Optical
- ☐ Eye exam record
  - ☐ Retinal camera photos
- ☐ Eyecare receipt
- ☐ Eyecare prescription

Medical Plan (Shopko Employees)
- ☐ Plan payment record
- ☐ Plan enrollment record
- ☐ Plan claims adjudication record
- ☐ Plan case management record

Please check to exclude:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): ______________________________

for the following date range: ___/___/___ FROM — ___/___/___ TO

Section C: Release Method

Records are to be released to: ☐ Patient ☐ Physician ☐ Other ______________________________

If to physician or other, please complete the following information:

NAME ADDRESS

PHONE NUMBER FAX NUMBER CITY STATE ZIP

Please indicate preferred method of delivery: ☐ Paper Record ☐ Electronic Record (PDF file via secure e-mail)

E-Mail Address: ______________________________

Section D: Purpose of Release

The purpose of this release of information is:

- ☐ for medical care
- ☐ an application for insurance
- ☐ payment of insurance claim
- ☐ disability determination
- ☐ personal use
- ☐ housing authority eligibility
- ☐ legal investigation or proceeding
- ☐ other: ____________

Section E: Duration of Release

This release is in effect through (not to exceed one year): ______________ unless rescinded by the patient in writing before that date or condition.

Section F: Signature

I authorize Shopko to disclose the above medical information. The information disclosed pursuant to this Release may be redisclosed by the recipient and will no longer be protected by our Privacy Practices. I understand that signing this release is voluntary.

Patient Signature: ______________________________ Date: ______________

If person other than patient, please supply supporting documentation and complete the following:

Signature of person authorized by patient: ______________________________ Date: ______________

Relationship to patient: ______________________________

The information contained in this document and the pages that follow is intended for the exclusive use of the addressee(s) and may contain confidential or privileged information. If you are not the intended recipient, please immediately notify the Privacy Office at ShopKo Stores Operating Co., LLC toll-free at 1-866-369-HIPA (4472) and destroy all copies and pages of this document.

*as defined by Wis. Stat. ch 146