Date: _____

PATIENT AUTHORIZATION FORM TO JOIN FRUTH Rx REWARDS PROGRAM

Name: _____

Address: _____

Phone number: _____ Fruth Rewards Number: _____

I authorize the Fruth Pharmacy to disclose health information identifying me so I can accrue Fruth Rx Rewards. The only information that will be disclosed is my name, address, phone number, and the fact that I purchased a prescription. This information will be disclosed to the Fruth Rx Rewards Program administrator.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to HIPAA Contact Person at Fruth Corporate Office, 4016 Ohio River Rd, Pt Pleasant WV 25550 or HIPAAcontact@fruthpharmacy.com.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In some cases, the recipient may re-disclose the information.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Signature: _____

Please list all persons for whom you are authorizing enrollment into the Rx Rewards Program

Print Name: _____ Relationship to Patient: Self_____

Print Name: _____ Relationship to Patient: _____

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