PATHMARK STORES, INC.

PRESCRIPTION RECORD RELEASE TO PATIENT OR PARENT/GUARDIAN OF MINOR

STORE#:____________________

DATE:______________________

NAME OF PATIENT:______________________________

DATE OF BIRTH:________________________________

ADDRESS:______________________________________

CITY, STATE, ZIP:_____________________________

DATE RANGE FOR REQUESTED RECORDS/RECEIPTS:

STARTING: (MONTH/YEAR)________________________

ENDING: (MONTH/YEAR)__________________________

ALL RECORDS MUST BE RELEASED TO THE PATIENT (OR LEGAL GUARDIAN)

ALL RECORDS OLDER THAN 16 MONTHS; MUST BE REQUESTED IN WRITING AND SENT TO:

PATHMARK STORES, INC.
PHARMACY OPERATIONS M-115
200 MILIK STREET
CARTERET, NJ 07008

PLEASE ALLOW FOUR TO SIX WEEKS FOR DELIVERY.

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(To Be Filled Out When Patient Picks Up Records)

PATIENT RELEASE VERIFICATION: DATE:____________________________

PRIOR TO RELEASING ANY PATIENT PRESCRIPTION RECORDS/RECEIPTS, THE IDENTITY OF THE PATIENT RECEIVING THE RECORDS MUST BE VERIFIED.

I ____ HAVE RECEIVED THE ABOVE REQUESTED PRESCRIPTION
(PRINT NAME)
RECORDS/RECEIPTS.

SIGNATURE:____

NAME:____

ADDRESS:____

CITY, STATE, ZIP:___________________________________

TYPE OF ID:_________________________________
(Driver's License or Other Photo ID)

VERIFIED BY:________________________________

PHONE#:_____________________________________

RX-88 R-2 5-03