



Authorization for a one-time written release of personal health information

Requesting the records of the following Plan Participant:

Last Name: _____

First Name: _____ Middle Initial: _____

Previous Last Name (if applicable): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ (mm/dd/yyyy) Phone Number: (_____) _____ - _____

CVS/caremark Plan Participant's Primary Cardholder Identification Number(s): _____

Name of Requestor (if different than above): _____

Relationship to Plan Participant:

Self

Legal guardian (Attach legal documentation)

Parent

Other: _____

(Attach legal documentation)

I hereby authorize CVS/caremark to release the following information for the above Plan Participant:

Statement of Cost (financial report) from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

Detailed Prescription History from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

Other health information (please specify): _____

from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

This information should be released to: Check if same as address above.

Name: _____

Organization/Entity: _____

Address: _____

City/State/Zip: _____

The purpose of this authorization request is:

At request of plan participant,

Required or requested by the recipient for purposes of _____

Other: _____

This Authorization will expire 90 days from the date of this authorization.

I understand that I have the right to revoke this Authorization at any time. This revocation will not affect any uses and/or disclosures already made based on this authorization before the revocation is received by CVS/caremark. The revocation must be in writing and mailed to the address below. I understand that CVS/caremark may not condition any treatment, payment, enrollment or my eligibility for benefits on my signing this Authorization. I understand that the information used and/or disclosed pursuant to this authorization may be rediscovered by the recipient and may no longer be protected by the federal privacy law.

I certify that the foregoing information is true and correct.

Signature: _____ Date: _____

Print Name: _____

If signed by someone other than the above-named plan participant, please describe your legal authority to act on behalf of the plan participant, and, if applicable: _____

(Attach supporting documentation)

Witness Signature: _____

Witness Name: _____ Date: _____

Please Return Form To:

CVS/caremark

Attn: Research Department

P.O. Box 6590

Lee's Summit, MO 64064