EXPRESS SCRIPTS®

Authorization to Use and Disclose Health Information

PLEASE PRINT CLEARLY

Patient's Name:_____ ID Number_____

Address:_____ SSN:_____
Street

_____ Date of Birth: _____/_____/_____
City, State, Zip MM DD YYYY

Plan Sponsor/Employer (if available) _____

[ ] Check here if Plan Sponsor is Department of Defense

I authorize Express Scripts, Inc. or one of its subsidiaries or affiliates to use or disclose my health information as described below. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and no longer protected by federal privacy regulations.

1. The following health information may be used or disclosed:
   [ ] PBM Prescription Claims Information
   [ ] Only Mail Order Pharmacy Records are requested

2. The health information identified above may be used or disclosed for the following purpose(s):

   _____

   _____

3. The health information identified above may only be disclosed to the following individual(s) or organization(s):

   Name: _____

   Address:_____

   E-mail Address _____

4. I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.

6. I understand that if this authorization is for the disclosure of health information for a research study, I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, I may not receive the treatment related to the research study.

7. I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. Information that has already been disclosed may not be further disclosed by Express Scripts,

Inc. once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

Express Scripts, Inc.
Claims Dept – Records/HQ21-06
8455 University Place Drive
St. Louis, MO 63121

8. I understand that I have a right to request and receive a copy of Express Scripts' Notice of Privacy Practices at www.express-scripts.com.

9. A photocopy of this authorization is as valid as the original.

10. I understand that this authorization will expire ten (10) years from the date signed below.

SIGNATURE

_____ _____
Signature of patient or patient's personal representative Date

_____
Printed name of patient or patient's personal representative

If signed by patient's personal representative, please complete the following and attach supporting documentation:

Relationship to patient: _____

Authority to act for the patient: _____

Prescription Claims Information is readily available for the previous ten years. Patients wanting prescription claim information sent to the address on file should call the number on the back of the prescription identification card

Members wanting PBM Prescription Claim Information sent to the address on file free of charge should call the number on the back of the prescription identification card. The Express Scripts website also provides all members the ability to access and print PBM Prescription Claim Information for free for the last 24 months of service by logging into www.express-scripts.com.

Please return the completed form to the address below and allow 6-8 weeks for the request to be processed. For those requests for PBM Prescription Claims Information not submitted by a member's legal personal representative, please also submit a check or money order for the non-refundable fee of $90.00.

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