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 redisclosed 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