



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
- Parent
- Legal guardian (Attach legal documentation)
- 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
PO Box 7074
Lee's Summit, MO 64064-7074