



**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