CVS/caremark™

PLAN MEMBER AUTHORIZATION FORM

Section A: Plan Member Information

For purposes of this authorization form, "CVS/caremark" means Caremark Rx, Inc. and its affiliates

Plan Member Name: **Plan Member Date of Birth:**

Address:

Telephone Number: **Primary Cardholder ID Number:**

E-mail Address: **Plan Member Social Security Number:**

Section B: Information about Me that May Be Used and/or Disclosed

The Personal Health Information about me that may be used and/or disclosed includes, but is not limited to, any information held by CVS/caremark for any time period about my:

- Treating providers of care (pharmacies, prescribing physicians, etc);
- Prescription records (drug names, dispensing dates, costs, etc);
- Demographic information (address, etc); and
- Eligibility information (dates of coverage, deductibles, etc).
- Other specific information: _____

Section C: Purpose

This authorization is made at my request. OR
Other purpose: _____

Person or Entity Authorized to Receive and Use Personal Health Information About Me:

Name: **Phone Number**:

Address:

Relationship to Me:

Section D: Expiration and Revocation

This authorization will automatically expire: (1) one year after _____ [date] **OR (2) if no date is specified in (1), one** year following the termination of my participation in a pharmacy benefit plan or drug discount card, as applicable, administered by CVS/caremark.

I understand that I have the right to revoke this authorization at any time, but that my revocation will not apply to any action that CVS/caremark has already taken in reliance on this authorization prior to receipt of my revocation. I understand that in order to revoke this authorization, I must send a **written** notice of revocation to the CVS/caremark contact listed below:

Contact Information:
CVS/caremark
Attn: Research Department
P.O. Box 6590
Lee's Summit, MO 64064

Section E: Signature / Authorization

I understand that the information used or disclosed in accordance with this authorization can be re-disclosed by the recipient and can no longer be protected by the federal Privacy Act. I acknowledge that my consent is voluntary. I understand that CVS/caremark may not condition any treatment, payment, registration or eligibility for benefits if I sign this form. I have had full opportunity to read and examine the contents of this form of authorization. I understand that by signing this form, I am authorizing CVS/caremark to use or disclose personal health information, as described in section b above to the person or entity named in section C for the purposes described above.

Signature: **Date:**

Note: If signed by someone other than the above-named plan member, please describe your legal authority to act on behalf of the plan member and, if applicable, attach support legal documentation.

_____

PLEASE RETURN THE SIGNED AUTHORIZATION FORM TO THE CONTACT PERSON LISTED IN SECTION D.
YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.