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:** R

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: Service Benefit Plan
P.O. Box 52080
Phoenix, AZ 85072

Section E: Signature/Authorization

I understand that the information used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy law. I acknowledge that my authorization is voluntary. I understand that CVS Caremark may not condition any treatment, payment, enrollment, or eligibility for benefits on whether I sign this form.

I have had full opportunity to read and consider the content of this Authorization Form. I understand that, by signing this form, I am authorizing CVS Caremark to use and/or disclose my 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.