



**Authorization for a one time 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: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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 Caremark to release the following information for the above-named Plan Participant:

- Statement of Cost from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)
- 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.

**Legal Copy Services, Inc.**  
PO Box 2845  
Grand Rapids, MI 49501-2845

The purpose of this authorization request is:

- At request of plan participant
- Required or requested by the recipient for purposes of \_\_\_\_\_
- Other: Litigation \_\_\_\_\_

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 Caremark. The revocation must be in writing and mailed to the address below. I understand that 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 participant and, if applicable, attach supporting documentation: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Date: \_\_\_\_\_