HIPAA Privacy Authorization for Release of Information

CVS Caremark

HIPAA Privacy regulations require that in order for Assurant's **the People Experience Center** to contact CVS Caremark to assist you with a claim issue, you must complete the following HIPAA Authorization Form.

Please complete the attached form and fax it to **the People Experience Center** at **1**-651-361-4023. You must also call **the People Experience Center** at **1**-866-324-6513 to discuss your claim issue.

Note: you do not need to return the signed forms to CVS Caremark unless you want them to discuss your claims with someone else (i.e. a spouse).

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 [ ] Legal guardian (Attach legal documentation)
[ ] Parent [ ] 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
P.O. Box 6590
Lees Summit, MO 64064