HIPAA Privacy Authorization for Release of Information

CVS Caremark

HIPAA Privacy regulations require that in order for Assurant's HR Services 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 HR Services at 651.361.4023. You must also call HR Services at 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