



Member Name _____ Date of Birth _____

Street _____

City _____ State _____ Zip Code _____

Member ID _____ Phone Number _____

AUTHORIZATION

I authorize the below named individual to make a request, to present or elicit evidence, to submit or obtain appeals information, or to otherwise act on my behalf with respect to health care and uses and disclosures of protected health information. I understand that personal medical information may be disclosed to the representative named below.

I understand that I may revoke this authorization at any time, in writing, by sending a letter to: Privacy Office Manager, CVS Caremark Corporation, 695 George Washington Highway, Lincoln, RI 02865, except to the extent that CVS Caremark Corporation has taken action in reliance on this authorization.

A copy of this authorization may be utilized with the same effectiveness as an original.

Member's Printed Name _____

Member's Signature _____ Date _____

REPRESENTATIVE INFORMATION

I, _____, hereby accept the above appointment. I certify that I have not been disqualified from acting as this member's representative, and I recognize that any fee I charge for representation may be subject to review and approval by the Secretary of the Department of Health and Human Services.

I am a / an _____.
(Professional status or relationship to the member, e.g. attorney, friend, relative)

Representative Signature _____ Date _____

Representative Address _____

City _____ State _____ Zip Code _____

Representative Phone Number _____

PLEASE COMPLETE THIS FORM AND MAIL TO:

**Attention: Privacy Office
CVS Caremark Corporation
695 George Washington Highway
Lincoln, RI, 02865**