**Instructions for Naming an Authorized Person**

**General Instructions: All fields are required to be completed unless otherwise specified.**

This form must be completed when a plan member wishes to name one or more individuals as authorized to access and, in some cases, act on his/her account information. A separate request form is required for each member on the account, as applicable, even if authorizing the same person. Please note that this form does not necessarily create a personal representative under the **Health Insurance Portability and Accountability Act** (HIPAA) and does not replace a Power of Attorney or other legal documents evidencing personal representative status under HIPAA.

**Section A: Member Information**

This section requests information related to the member who is seeking to name an authorized person. Since this information is used for both identification and verification purposes, the information included in this section should match the most current information for the member/subscriber in CVS Caremark® systems. Please be aware that this form may be denied if the information on the form does not match the information in our systems.

**Section B: Type of Authorized Persons**

Members can choose one of three available levels of authorization for the authorized person: ongoing authorization, ongoing authorization and right to make account decisions, and one-time authorization/release. The levels are described below.

* **Ongoing Authorization (Account Inquiries Only):** If you select this option, the authorized person is only allowed to make inquiries about your account. CVS Caremark is allowed to disclose your protected health information (PHI) to that individual, such as claims, enrollment, billing and appeals. The authorized person will not be allowed to make changes to your account.
* **Ongoing Authorization and Right to Make Account Decisions (Account Inquiries and Changes):** If you select this option, the authorized person will have all the rights that you currently have to make changes to your account. This means that the authorized person will be allowed to make inquiries about your account, to access your PHI, and to request and make changes and updates to your account, such as changing your address on file.
* **One-Time Authorization/Release:** The one-time authorization to disclose PHI allows you to specify what information about you or your account may be released on a one-time basis, including information about your:
* Treating providers of care (pharmacies, prescribing physicians, etc);
* Prescription records (drug names, dispensing dates, costs, etc);
* Demographic information (your date of birth, address, etc); and
* Eligibility information (dates of coverage, deductibles, etc).

**Section C: Authorized Person Information**

The requested information will be used by CVS Caremark for identification and verification purposes. The authorized person will be required to disclose this information during a phone call if he/she wishes to receive PHI about you.

**Time Period of Authorization**: If no termination date is entered, the request will remain in effect until the member is no longer a member of a plan administered by CVS Caremark.

**Authorization to Disclose My Information**

**Section A: Member Information**

For purposes of this authorization form, CVS Caremark means Caremark Rx, Inc. and its affiliates.

Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Cardholder ID Number:\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Social Security Number: \_\_\_\_\_\_\_\_\_\_\_

**Section B: Information About Me That May be Disclosed**

* **Account Inquiries Only:** Any information related to my CVS Caremark account, including but not limited to my demographic information, claims, drug history, enrollment, billing and appeals.
* **For a One-Time Authorization/Release only:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Member to insert information that may be disclosed.]

**Section C: Authorized Person Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time Period of Representation: \_\_\_\_\_\_\_\_\_\_\_

**Section: Authorization and Signature**

I hereby authorize CVS Caremark and its affiliates (“CVS Caremark”) to disclose the information about me listed in Section B to the person named in Section C. This authorization is at my request. I understand that the information disclosed pursuant to this authorization may be re-disclosed by the person I have authorized as listed in Section C and may no longer be protected by federal privacy law. I understand that this authorization will remain in effect until I am no longer a member of a plan administered by CVS Caremark unless I cancel it before then. I may cancel it at any time by writing to the address below. I understand that my cancellation will not apply to any information disclosed before CVS Caremark receives my cancellation.

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 I am entitled to a copy of this authorization after I have signed it. By signing this form, I am authorizing CVS Caremark to disclose my protected health information as described in Section B above to the person named in Section C at my request.

**Authorization to Make Account Changes (Account Inquiries and Changes)**

□ By checking this box, I understand that I am authorizing the person named in Section C to make any inquiries and/or changes to my account that I can make.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_**

Note: If signed by someone other than the above-named member, please describe your legal authority to act on behalf of the member and, if applicable, attach support legal documentation.

**Mail this form to:**

CVS Caremark Customer Care Correspondence, P.O. Box 6590, Lee’s Summit, MO 64064