



MinuteClinic
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize MinuteClinic to use or disclose my health information as described in this authorization.

- Name of specific person/organization (or class of persons) authorized to receive and use the information. Please include address or fax number:

- Name of person/organization authorized to make the requested use or disclosure. Please include Patient name, and date of birth.

- Specifically describe the protected health information to be used or disclosed such as date of service, type of service, level of detail to be released, etc.:

- Purpose of the request:

- Right to revoke:* I understand that I have the right to revoke this authorization at any time by notifying MinuteClinic in writing at: CVS Caremark - MinuteClinic, Attn: MinuteClinic Privacy Office, One CVS Drive, Woonsocket, RI 02895. I understand that a revocation is only effective after it is received and logged by MinuteClinic. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

MinuteClinic may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

- I understand that after this information is disclosed, the recipient may re-disclose it.

- This authorization shall be in force and effect until (specify date or event that relates to the patient or the purpose of the use or disclosure) _____ at which time this authorization to use or disclose this protected health information expires.

Printed Name

Date

Signature

Date

Individual for whom you are Guardian
(If applicable)

Date

Return this completed form to:
CVS Caremark - MinuteClinic Attn: MinuteClinic Privacy Office
One CVS Drive, Woonsocket, RI 02895