CVS Pharmacy DISCLOSURE AUTHORIZATION FORM
One CVS Drive, Woonsocket, RI 02895
Fax (401) 652-1593

PATIENT REQUESTING DISCLOSURE

Name: _____
Address: _____
Address: _____
Date of Birth _____

I hereby authorize CVS Pharmacy to disclose my Patient Prescription Record (PPR), reflecting my prescription history and any other pharmacy services I have received from CVS Pharmacy as set forth below:

1. My Patient Prescription Record (PPR), may be disclosed to the following person(s) categories of person or entities:
   Name: Legal-Ease Digital Imaging
   Address: P.O. Box 1017 Flint, MI 48501-1017
   Address: _____

2. Purpose of the release of this information

   ☐ At the request of Patient/Patient's personal representative.
   ☐ Other: _____

3. I understand that my PPR may include information related to treatment of mental health condition, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases or communicable diseases. I understand that the information, if any, pertaining to any of the conditions described above may be released.

   ☐ I authorize the release of this information.
   ☐ I do not authorize the release of this information.

4. I understand that I may cancel this authorization at any time by writing to CVS Pharmacy Privacy Office, One CVS Drive Woonsocket, RI 02895, or fax to 401-765-9304, except to the extent that CVS Pharmacy has taken action in reliance on this authorization.

5. I understand that signing this authorization is voluntary and that this authorization will not affect my ability to obtain treatment from the CVS Pharmacy, any payment for treatment or enrollment or eligibility for benefits. A photocopy or facsimile of this signed Authorization is as valid as the original and will be accepted.

6. I understand that if the person or entity that receives my PPR is not required to comply with the applicable privacy regulations, the information described above may be redisclosed by the recipient and no longer be protected by those regulations.

7. I understand that I have the right to receive a copy of this Authorization.

8. This authorization will expire 6 months from the date I sign it as shown below on this authorization unless I enter a different expiration date here _____.

_____ _____
Signature of Patient or Personal Representative * Date

*If signed by someone other than the patient, please explain your authority to act on behalf of the patient: _____