



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: (____) _____ - _____

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 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: MINUTE MAN SERVICES, INC.
Organization/Entity: _____
Address: 3318 N. MAIN ST.
City/State/Zip: ROYAL OAK, MI 48073

The purpose of this authorization request is:
 At request of plan participant
 Required or requested by the recipient for purposes of LEGAL REVIEW
 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 Caremark. The revocation must be in **writing** and mailed to the address below. I understand that 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 participant and, if applicable: _____
(Attach supporting documentation)

Witness Signature: _____
Witness Name: _____ Date: _____

Please Return Form To:
Caremark, Attn: Off Line Support
6950 Alamo Downs Pkwy, Ste 110
San Antonio, TX 78238
(Fax) 210 706-2401