One CVS Drive, Woonsocket, RI 02895
Fax (401) 652-1593

CVS/pharmacy AUTHORIZATION FORM

PATIENT REQUESTING DISCLOSURE

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

I hereby authorize CVS/pharmacy to disclose my Patient Prescription Record (PPR), reflecting information regarding my pharmacy services as set forth below:

1. My Patient sed to the following person(s):
   Name: ___
   Address: ___
   Address: _____

2. I understand that I may revoke this authorization at any time by writing to CVS/pharmacy Privacy Office, 1 CVS Drive, Woonsocket, RI 02895, or fax to 1-401-652-1593, except to the extent that CVS/pharmacy has taken action in reliance on this authorization.

3. I understand that I am signing this Authorization of my own free will and that this authorization will not affect my ability to obtain treatment from the Pharmacy. I hereby state that this disclosure is at my request. A photocopy or facsimile of this signed authorization is as valid as the original and will be accepted.

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

5. This Authorization will expire 6 is authorization unless otherwise indicated here

_____ _____
Signature of Patient or Personal Representative* Date

*To the patient's personal representative, explain your authority to act on behalf of the patient: _____
_____
_____
_____