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:

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

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- 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.:

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- Purpose of the request:

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- *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