Authorization for Disclosure of Protected Health Information (PHI)

Patient Name (Records to be disclosed): _____

Street: _____

City, State, ZIP Code: _____

Date of Birth: _____

1. **Records to be disclosed:**

☑ My complete Patient Prescription Record (PPR), which reflects my prescription history and any other pharmacy services, including immunizations, I have received from CVS Pharmacy

☐ My COVID-19 vaccination history

☐ Other: _____
Specify a vaccination to be disclosed or date range

2. **My Records may be disclosed to the following person or company:**

Person or Company Name: Legal-Ease Digital Imaging LLC

Address: 2496 Meadowcroft Dr Burton, MI 48519

3. **I authorize CVS Pharmacy to disclose my Records for the purpose of:**

☐ At the request of Patient or Patient's Personal Representative (no specific purpose)

☑ Specific Purpose: Litigation

4. **This Authorization will expire 6 months from the date I sign it as shown below unless I enter a different expiration date HERE:** _____

5. **By signing below, I understand and agree that:**
   - My Records may include sensitive information related to the treatment of mental health conditions, alcohol or substance abuse, sexually transmitted diseases like HIV/AIDS or other communicable and non-communicable diseases, and genetic marker information.
   - I may cancel this authorization at any time by writing to CVS Pharmacy at the address, email or fax listed below, except to the extent CVS Pharmacy has acted in reliance on this authorization.
   - I understand that signing this authorization is voluntary and that this authorization will not affect my ability to obtain treatment, payment for treatment, or enrollment or eligibility for benefits for CVS Pharmacy. A photocopy or facsimile of this signed Authorization is as valid as the original and will be accepted.
   - Whoever gets my PHI may share it with others. That means federal or state privacy laws may no longer protect my PHI.
   - I can mail the completed form to **One CVS Drive, MC-B120, Woonsocket, RI 02895** or fax it to **401-652-1593**. I can also email it to PrescriptionRecordSvcCenter@cvshealth.com but I understand that communications sent by email are not secure unless they are sent using a technology that encrypts the email. There is a possibility that information included in an unencrypted email can be intercepted and read by other parties.
   - I understand that I have the right to receive a copy of this Authorization.

_____ _____

Signature of Patient/Personal Representative** **Date**

***If signed by someone other than the patient, please print your full name and explain your authority to act on behalf of this patient (CVS Pharmacy may request additional paperwork):* _____

_____