CORAM PATIENT AUTHORIZATION FORM
One CVS Drive, Woonsocket, RI 02895

PATIENT REQUESTING DISCLOSURE

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

I hereby authorize Coram/ Pharmacy to disclose my prescription records reflecting my treatment history and any other Coram services that I have received from Coram (collectively the "Medical Records") as set forth below:

1. My Medical Records may be disclosed to the following person(s) categories of person or entities:
   Name: _____
   Address: _____
   Address: _____

2. Purpose of the release of this information
   - ☐ At the request of Patient/Patient's personal representative.
   - ☐ Other: _____

3. I understand that my Medical Records 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 Coram's Privacy Office, One CVS Drive Woonsocket, RI 02895, except to the extent that Coram 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 Coram, any payment for treatment or enrollment or eligibility for benefits. A photocopy of 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 Medical Records is not required to comply with the applicable privacy regulations, the information described above may be re-disclosed 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 12 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:
_____