



Authorization to Use and Disclose Health Information

PLEASE PRINT CLEARLY

Patient's Name: _____ ID Number _____

Address: _____ SSN: _____
 Street _____

_____ Date of Birth: ____/____/____
 City, State, Zip MM DD YYYY

Plan Sponsor/Employer (if available) _____

Check here if Plan Sponsor is Department of Defense

I authorize Express Scripts, Inc. or one of its subsidiaries to use or disclose my health information as described below. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and no longer protected by federal privacy regulations.

1. The following health information may be used or disclosed:
 Prescription Claims Information/ Prescription History (PBM records)
 Check here if only mail order records are requested

2. The health information identified above may be used or disclosed for the following purpose(s):

3. The health information identified above may only be disclosed to the following individual(s) or organization(s):
 Name: _____
 Address: _____

4. I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health and/or substance abuse.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.

6. I understand that if this authorization is for the disclosure of health information for a research study, I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, I may not receive the treatment related to the research study.
7. I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. Information that has already been disclosed may not be further disclosed once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

Express Scripts, Inc.
P.O. Box 66561
St. Louis, MO 63166-6561
8. I understand that I have a right to request and receive a copy of Express Scripts' Notice of Privacy Practices at www.express-scripts.com.
9. A photocopy of this authorization is as valid as the original.
10. I understand that this authorization will expire one hundred eighty (180) days from the date signed below.

SIGNATURE	
_____	_____
Signature of patient or patient's personal representative	Date

Printed name of patient or patient's personal representative	
If signed by patient's personal representative, please complete the following:	
Relationship to patient: _____	
Authority to act for the patient: _____	

Prescription Claims Information is readily available from 2002 to present. Patients wanting their own prescription claim information sent to their address on file should call the number on the back of their prescription identification card.

Please return completed form along with a check or money order for the non-refundable processing fee of \$75.00 to:

Express Scripts, Inc.
Attn: Legal Department- Records
One Express Way
Mail Route HQ2E03
St. Louis MO 63121
866-254-2313 (fax)

Please allow 6-8 weeks for the request to be processed.
For questions or concerns, please call toll-free 800-332-5455, x344102.