

CVS PHARMACY

AUTHORIZATION FOR RELEASE OF PRESCRIPTIONS/ RECORDS TO HEALTH CARE PROVIDER OR EMERGENCY RELIEF AGENCY

MY NAME: _____ DATE: _____

RELEASE TO SIENA COLLEGE HEALTH SERVICES

The cost of my prescriptions (and/or the prescriptions of my dependent child(ren)) to be dispensed by CVS Pharmacy will be billed to the account of Siena Health Services.

I hereby authorize CVS Pharmacy to release information concerning my prescription records (and/or the prescription records of my dependent child(ren)) to Siena College.

CVS Pharmacy may use an outside agent, bound not to use or release any confidential information, to assist in processing the billing of my account. I consent to information concerning my prescription records being released to this agent for this purpose.

I acknowledge that CVS Pharmacy is authorized to release the prescription records (and/or my dependent child(ren)) in accordance with this authorization until such time as I withdraw this authorization in writing to CVS Pharmacy. An authentic copy of this form is as binding as the original.

Signature: _____

Permanent Address: _____

City/State/Zip Code: _____

Phone #: _____

Date of Birth: _____

Student ID #: _____

Allergies to Drugs: _____