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100 Parsons Pond Drive
Franklin Lakes, New Jersey 07417-2603

Letter of Satisfactory Assurances

In compliance with the standards for the use and disclosure of protected health information ("PHI") for judicial and administrative proceedings under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR 164.512(e), to the best of my knowledge, information and belief:

1. I have made a good faith attempt to provide written notice to the individual whose records I am requesting (or, if the individual's location is unknown, to mail a notice to the individual's last known address);
2. The notice informed the individual of my request and included sufficient information about the litigation or proceeding in which the PHI is requested to permit the individual to raise an objection to the court or administrative tribunal; and
3. That the time for the individual to raise an objection to the court or administrative tribunal has elapsed and: i) no objections were filed; or ii) all objections that were filed by the individual have been resolved by the court or administrative tribunal and the disclosures being sought are consistent with such resolution.

Signature:_____

Printed Name:_____

Organization: _____

Date _____

Name of Individual (whose records we are requesting):_____

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PATIENT AUTHORIZATION FOR RELEASE OF PRESCRIPTION DRUG RECORDS

THIS AUTHORIZATION IS FOR COPIES OF RECORDS ONLY

MEDCO HEALTH SOLUTIONS AND ITS AFFILIATES ("Medco") are hereby authorized to release records relating to prescription drugs dispensed to the below Patient ("Patient") during the period: _____ (month, day, year) to _____ (month, day, year)

Patient whose prescription drug records will be released:

Patient's Name (print)	
Member ID No. (Cardholder's No.)	
Patient's Last Known Address including Zip	

To the extent that Medco has such information about Patient, this authorization includes the release of prescription information concerning AIDS, ARC (AIDS related complex), AIDS-related conditions, treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, reproductive health services and sexually transmitted diseases which may include, but are not limited to, venereal disease, hepatitis, syphilis and gonorrhea.

The records authorized for release are to be forwarded to ("Designee"):

Designee Name	
Street address, including zip code	

Over - Please sign and date on the back.

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This authorization shall expire one (1) year from the date hereof. The Patient may revoke this authorization at any time by writing to Medco. The Patient's revocation of this authorization will not affect any action Medco has taken in reliance of this authorization before Medco received the written notice of revocation. The Patient understands that Medco will not condition treatment, payment, enrollment, or the eligibility for health plan benefits on whether the Patient signs this authorization. The Patient also understands that the Designee may not be subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or any other health information privacy laws, and that the Designee may further disclose the Patient's health information and it may no longer be protected by HIPAA or other health information privacy laws.

Signature of Patient or Personal Representative **Date**

If this request for Patient's records is being made by a Personal Representative on behalf of the Patient, then fill out the following sections.

Personal Representative Name (print)	

Please attach the legal document establishing you as the Patient's Personal Representative if you have not previously submitted it to Medco. One of the appropriate boxes below must be filled out.

Describe your authority to act for the Patient
(check appropriate box) ☐ Power of Attorney or equivalent ☐ Court Order ☐ Parent of minor child ☐ Other (please specify)

IF THE PATIENT IS DECEASED Relationship of Personal Representative to deceased Patient
(check appropriate box) ☐ Executor ☐ Administrator ☐ Other (please specify) **(A photocopy of the deceased Patient's death certificate or an equivalent must be received with this signed patient authorization form)**