



**BENEFICIARY AUTHORIZATION FORM**  
**FOR VERBAL RELEASE**

**PLEASE FILL IN ALL INFORMATION REQUESTED.**

**SECTION I: BENEFICIARY INFORMATION**

LAST NAME, FIRST NAME (PLEASE PRINT)	DOB (MM/DD/YYYY)
STREET ADDRESS	PHONE NUMBER (AREA CODE)
CITY	STATE
CARDHOLDER ID #	ZIP CODE
EMAIL ADDRESS	SOCIAL SECURITY NUMBER

**SECTION II: INFORMATION THAT MAY BE USED OR DISCLOSED**

The Personal Health Information about me that may be used and/or disclosed includes, but is not limited to, any information held by SilverScript Inc. for any time period about my:

- Treating providers of care (prescribing physicians, pharmacies, etc.)
- Prescription records (drug names, dispensing dates, costs, etc.)
- Demographic information (address, phone number, etc.)
- Eligibility Information (dates of coverage, deductibles, etc.)
- Other specific information: \_\_\_\_\_

**SECTION III: PERSON OR ENTITY AUTHORIZED TO USE OR RECEIVE MY PERSONAL HEALTH INFORMATION**

LAST NAME, FIRST NAME (PLEASE PRINT)	
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
PHONE NUMBER (AREA CODE)	RELATIONSHIP TO ME

**SECTION IV: PURPOSE OF RELEASE**

- This authorization is made at my request
- Other purpose: \_\_\_\_\_

**SECTION V: EXPIRATION AND REVOCATION**

This authorization will automatically expire: (1) one year after\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ or (2) one year following the termination of my participation in a pharmacy benefit plan or drug discount card program, as applicable, administered by SilverScript Inc.

I understand that I have the right to revoke this authorization at any time, but that my revocation will not apply to any action that SilverScript Inc. has already taken in reliance on this authorization prior to receipt of my revocation. I understand that in order to revoke this authorization, I must send a **written** Notice of Revocation to the SilverScript Inc. contact listed below:

Authorization Processing  
SilverScript  
Research Department  
P.O Box 832407  
Richardson, Texas 75083

**SECTION VI: SIGNATURE / AUTHORIZATION**

I understand that the information used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy law. I acknowledge that my authorization is voluntary. I understand that SilverScript Inc. may not condition any treatment, payment, enrollment, or eligibility for benefits on whether I sign this form.

I have had full opportunity to read and consider the content of this BENEFICIARY AUTHORIZATION FORM. I understand that, by signing this form, I am authorizing SilverScript Inc. to use and/or disclose my personal health information as described in SECTION II above to the person or entity named in SECTION III for the purpose described above.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*NOTE: If signed by someone other than the above-named beneficiary, please describe your legal authority to act on behalf of the beneficiary and, if applicable, attach supporting legal documentation.*

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**Please return the BENEFICIARY AUTHORIZATION FORM to the Contact Information listed in SECTION IV.  
You are entitled to a copy of the BENEFICIARY AUTHORIZATION FORM after you sign it.**