# Show us what makes you happy.

**Your artwork could be featured in the 2022 Coram* calendar.**
All Coram patients age 5 to 17 are invited to send in their original artwork. It's a fun way to share your joy with others every day in 2022.

## Here's what you need to do:

1. **Create original** artwork about whatever makes you happy.** Use the next page or any paper that's 8.5" x 11" or smaller.

2. **Fill in your contact information on the form below.** And be sure to have your parent or guardian sign and date the attached Release and Consent and Health Insurance Portability and Accountability Act (HIPAA) forms.

3. **Email your artwork and signed forms by October 22, 2021.** Submit your artwork as a PDF or JPG to **CoramCares4Kids@CVSHealth.com**.

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**Your contact information.** Fill in and email this form with your artwork and Release and Consent and HIPAA forms. If your artwork is chosen, we'll need to contact you.

Patient Name (Minor)

Age

Parent or Legal Guardian

Email Address

Street Address

City, State

ZIP code

*Coram® CVS Specialty® Infusion Services

**Artwork depicting imagery that is the trademarked or considered the intellectual property of another brand/company/entity will not be accepted.

Artwork will be selected at judges' sole discretion based on creativity and number of entrants.

Use this page to create artwork about something that makes you happy!

**Fill in and Return**

# Release and Consent

**I,** _____ ,
hereby grant Coram, LLC, a CVS Health company, on behalf of itself and its subsidiaries and affiliates ("CVS") the right to photograph, videotape/film, record, broadcast, and/or telecast me and use my identity, likeness, statements, and quotations to produce, reproduce, publish and republish internal/external promotions/marketing videos and other promotions/marketing materials for CVS in any media. I also give CVS permission to use the finished photographs, videos, recordings, reproductions and copies of the originals for educational, instructional or sales purposes. These photographs, images, videos and/or recordings may also appear in presentations given to the investor community and analysts by CVS Senior Executives. CVS is the sole owner of all rights to photographs, images, videos, and recordings that include my identity and likeness in them and can repurpose these at any time without my approval. I represent and warrant that I shall neither sue nor bring any proceeding against CVS or any third party for any use or exploitation of my identity, likeness, statements, or quotations in connection with the materials described herein, including but not limited to any action asserting an invasion of privacy, breach of my right of publicity, defamation, or copyright infringement.

**I certify that I am of legal age.**

**Signature:**_____

**Date:** _____

**Adult Name (print):** _____

**As parent or guardian of the minor named below,** I acknowledge that I am signing this consent and release on behalf of such minor and I hereby release CVS, its employees, subsidiaries, successors, agents and assigns and any others acting with its permission or under its authority from any and all claims arising out of the foregoing.

**Minor Name (print):** _____

**Signature of Parent or Guardian:** _____

**Fill in and Return**

# HIPAA Authorization Form

**I,** _____ , give permission to Coram, LLC, a CVS Health company, on behalf of itself and its subsidiaries and affiliates ("CVS") to use and disclose my Protected Health Information, including but not limited to, my name and other personal information (such as my age, gender, race and place of residence and photographic images of me), my medical condition, and treatment program (including any drug therapy I am on and/or the name of any drug I am using to treat the condition) ("Protected Health Information"). This information may be used and disclosed by CVS for marketing purposes, including to the investor community and to the general public.

This Authorization expires three years after I sign it as shown below. I understand that, once disclosed, my Protected Health Information may no longer be protected by federal privacy law and may be further used and disclosed without my permission.

I understand that I am not required to sign this Authorization, and that CVS may not condition any treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

I understand that I have the right to cancel this Authorization at any time, but that any cancellation will not apply to any Protected Health Information that CVS has already used or disclosed based on this Authorization and before it receives my cancellation. I understand that in order to cancel this Authorization, I must send a written notice stating that I am cancelling this Authorization to CVS Health Attn: Privacy Office, One CVS Drive, Woonsocket Rhode Island 02895.

I have had full opportunity to read and consider the contents of this Authorization. I understand that, by signing this Authorization, I am giving CVS permission to use and/or disclose my Protected Health Information as described above.

**Signature:**_____

**Date:** _____

**Note:** If the person signing this form is not the Individual, please describe your relationship to the Individual and your legal authority to sign it on behalf of the Individual:

_____

**As parent or guardian of the minor named below,** I acknowledge that I am signing this consent and release on behalf of such minor and I hereby release CVS, its employees, subsidiaries, successors, agents and assigns and any others acting with its permission or under its authority from any and all claims arising out of the foregoing.

**Minor Name (print):** _____

**Signature of Parent or Guardian:** _____