

personal representative authorization form



By completing this form you will be granting Fallon Community Health Plan (FCHP) permission to release your personal information to one or more personal representatives. Only the information indicated below will be released to your personal representative. This personal representative authorization is valid for **one year only from the date of signature**.

Member ID number: _____ Member name: _____

Medicare Beneficiary Number (if applicable): _____

Member address: _____

Member telephone: _____ - _____ - _____ Member date of birth: ____ / ____ / ____

I request and authorize FCHP to release personal health information to:

Name: _____

Address: _____

City, state: _____ ZIP code: _____

Relationship to member: _____

Personal representative telephone: _____ - _____ - _____

This request and authorization applies to:

- Financial information (e.g., premium billing, claims payment, etc.)
- Health care information (e.g., health/illness information, appeals, claims diagnosis)
- Demographic information only (e.g., address changes, etc.)
- Sensitive health information (e.g., HIV/AIDS status)
- Mental health records (e.g., payment, diagnosis, etc.)

I authorize my personal representative to act on my behalf in connection with any appeals for coverage.

I may withdraw my authorization at any time by submitting a written request to FCHP's privacy clerk. If I do, I understand that my PHI may have already been released to my personal representative after I gave permission. I have carefully read and understand the above and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons listed above.

Member's signature: _____ Date: _____

Personal Representative: I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended or prohibited from practice before the Department of Health and Human Services; that I am not as a current or former employee of the United States, disqualified from acting as a Medicare beneficiary's representative.

Personal Representative Signature: _____

Mail completed form to: **HIPAA Privacy Clerk**
Fallon Community Health Plan
10 Chestnut St.
Worcester, MA 01608

FOR FCHP USE ONLY

Issued by: _____ Date sent: _____

Date received by privacy clerk: _____

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