

authorization for release of personal information

Member ID number: _____ Member name: _____
Member address: _____
Member telephone: _____ - _____ - _____ Member date of birth: ____ / ____ / ____

This authorization allows the recipient to use or disclose my protected health information (PHI) for the following purpose:

I request and authorize FCHP to release personal information to:

Name: _____

Address: _____

City, state: _____ ZIP code: _____

Telephone: _____ - _____ - _____

This request and authorization applies to:

Personal information relating to the following: _____

Valid from date: ____ to date: ____

I understand that:

- I may withdraw my authorization at any time by submitting a written request to _____ Department. If I do, I understand that my personal information may have already been released after I gave permission.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal or state privacy laws.
- I understand that this authorization will automatically expire on ____ or when the following event occurs:

- I understand that I have the right to refuse to sign this authorization and that my refusal will not result in the condition of treatment, payment, enrollment in FCHP or eligibility for benefits.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Member (or personal representative) signature: _____

Print name: _____

Date: _____

If signed by member's personal representative, please attach documentation of authority (e.g., power of attorney, signed authorization).

Mail completed form to:

Fallon Community Health Plan
10 Chestnut St.
Worcester, MA 01608

