

veteran's office authorization for release of personal information

Member ID number: _____ Member name: _____

Member address: _____

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

Effective _____ / _____ / _____ I request and authorize Fallon Community Health Plan to release my (monthly/quarterly) premium bill to the following veteran's office for payment:

Veteran's office name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ - _____ - _____ Veteran office contact person: _____

Veteran's office agrees to be billed and be responsible for the Fallon Senior Plan TM monthly plan premium payments for the above listed member.

Veteran's office approval signature _____ / _____ / _____
Date

This request and authorization applies to:

Personal information relating to the following: premium billing information only

I understand that:

- All notices regarding premium payment change(s) or non-payment will be sent to me, and it will be my responsibility to contact the veteran's office to follow up on the change(s) or non-payment.
- I may withdraw my authorization at any time by submitting a written request to the FCHP Premium Billing 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 one year from the date of signature.
- 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: Premium Billing Department
Fallon Community Health Plan
10 Chestnut St.
Worcester, MA 01608

