fallonhealth

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Member information

Member name: _____ Date of birth: _____

Member address: _____

City: _____ State: _____ Zip: _____

Request details

Check all applicable:

☐ I request and authorize Fallon Health to RELEASE personal health information to:

☐ I request and authorize Fallon Health to OBTAIN personal health information from:

Name/Facility: _____

Address: _____

Purpose of request:

☐ Care coordination ☐ At my personal request ☐ Legal request

☐ Transfer of care ☐ Other: _____

I authorize the release of the following information for dates of services:

from: _____ to _____

Information to be obtained or released:
I specifically authorize the disclosure of all medical information and the specific protected records initialed below relating to the above-mentioned member.

Statutorily protected records: (Member initial all that apply)

Alcohol/Drug use _____ Genetic testing _____ Sexually transmitted diseases _____
Behavioral health _____ HIV/AIDS _____ Other: _____
Domestic violence_____ Sexual assault _____

I understand that unless otherwise revoked or specified, this authorization is valid for 12 months from the date of my signature.

Please specify an expiration date if other than 12 months: _____

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Authorization and signature

- I understand that I have the right to revoke this authorization at any time by sending written notice to the person or entity authorized to make the disclosure described on the previous page.
- I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that this information, once disclosed, may be subject to re-disclosure by the receiving entity and may no longer be protected under HIPAA or other privacy laws.
- I understand that if I have allowed the disclosure of records that identify me as having or as having had a substance use disorder, the records may be protected under 42 CFR Part 2, and *may* be prohibited from being re-disclosed without my express written authorization.
- I understand that I have the right to refuse to sign this authorization and that my refusal will not affect any treatment, payment, enrollment in or eligibility of benefits for Fallon Health.

Name: (PRINT) _____

Signature _____ Date: _____

If signed by someone other than the member, signer's relationship to member (i.e., guardian, authorized representative): _____

Mail completed form to:
Fallon Health • 10 Chestnut St. • Worcester, MA 01608