# AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Member name: _____ Date of birth: _____

Member address: _____

City: _____ State: _____ Zip: _____

☐ 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 ☐ Personal ☐ Legal ☐ 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. I do not give my permission for any other use or re-disclosure of this information.

**Statutorily Protected Records:** (Member initial all that apply)

| | | |
|---|---|---|
| Alcohol/Drug Use _____ | Genetic Testing _____ | Sexually Transmitted |
| Behavioral Health _____ | HIV/AIDS _____ | Diseases _____ |
| Domestic Violence_____ | Sexual Assault _____ | Other: _____ |

I understand unless otherwise revoked or specified, this authorization is valid for 12 months.

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

- 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 above.
- I understand that revocation will not apply to information that has already been released in response to this 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: _____

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