Veteran's Office Authorization for Release of Personal Information

Member name: _____ Member ID number: _____

Member address: _____

Member telephone: 1- - - _____ Member date of birth: / / _____

Effective / / I request and authorize Fallon Health 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 Health Weinberg 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 Fallon Health 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 Fallon Health 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 or fax completed form to: Premium Billing Department
Fallon Health
10 Chestnut St
Worcester, MA 01608