Restrictions form

Member name: _____ Member ID number: _____

Member address: _____

City, State, Zip_____

Member telephone: _____ Member date of birth: _____

I request Fallon Health to NOT release personal information to:

Name: _____

Address _____

City, State, Zip_____

Relationship to member: _____

Telephone: _____

Valid from date: _____ Valid to date (if applicable): _____

This request applies to:

☐ Financial information (premium billing, claims payment, etc.)
☐ Health care information (Health/illness information, appeals, claims diagnosis)
☐ Demographic information only (address changes, etc.)

I may withdraw my authorization at any time by submitting a written request to Fallon's Customer Service Department. If I do, I understand that my personal information may have already been released before I requested this restriction.

Member (or personal representative) signature: _____

Relationship to member (if personal representative): _____

Print name: _____ Date: _____

Mail completed form to:

Fallon Health
10 Chestnut St.
Worcester, MA 01608

FOR FALLON USE ONLY

Issued by: _____ Date sent: _____

Date reviewed by privacy clerk: _____