

Important!

Important! This information is about your Fallon Health MassHealth benefits. It needs to be translated right away. Fallon can translate it for you. If you need help with translation or other help, call Fallon at 1-800-341-4848.

¡Importante! Esta información es sobre sus beneficios de Fallon Health MassHealth. Necesita traducirse de inmediato. Fallon puede traducírsela. Si necesita ayuda con la traducción, o cualquier otro tipo de ayuda, llame a Fallon al 1-800-341-4848. (SPA)

ສໍາຄັນ! ຂໍ້ມູນນີ້ແມ່ນກ່ຽວກັບເງິນຊ່ວຍເຫຼືອ Fallon Health MassHealth ຂອງທ່ານ. ມັນຈໍາເປັນຕ້ອງມີການແປພາສາໃນທັນທີ. Fallon ສາມາດແປມັນໃຫ້ທ່ານໄດ້. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເລື່ອງການແປພາສາ ຫຼືຄວາມຊ່ວຍເຫຼືອອື່ນ, ໃຫ້ໂທຫາ Fallon ທີ່ເບີ 1-800-341-4848. (LAO)

重要事項! 本資訊與您在Fallon Health MassHealth 的福利有關。請即刻瞭解其中的內容。Fallon 可以為您提供翻譯。如果您需要他人協助翻譯或需要其他協助，請致電Fallon，電話1-800-341-4848。(CHI)

Enpòtan! Enfòmasyon sa yo konsène avantaj Fallon Health MassHealth ou. Nou dwe tradui yo touswit. Fallon kapab tradui yo pou ou. Si ou bezwen èd pou tradiksyon an oswa lòt èd, rele Fallon nan nimewo 1-800-341-4848. (HC)

ຕົກ້ໍາສໍາຄັນ! ຕົກ້ໍາສໍາຄັນນີ້ແມ່ນກ່ຽວກັບຜົນປະໂຫຍດຂອງ Fallon Health MassHealth ທີ່ທ່ານໄດ້ຮັບ. ຖ້າທ່ານຕ້ອງການການແປພາສາ ຫຼືຄວາມຊ່ວຍເຫຼືອອື່ນ, ຈົ່ງສືບຕໍ່ສາຍສູນຮູບເງິນຊ່ວຍເຫຼືອຂອງທ່ານ ຫຼືໂທຫາ Fallon ທີ່ເບີ 1-800-341-4848 (CAM)

Importante! Esta informação se refere aos seus benefícios do programa MassHealth de Saúde da Fallon. Deve ser traduzida imediatamente. A Fallon pode providenciar a tradução para você. Caso necessite ajuda com tradução, ou qualquer outro tipo de ajuda, ligue para a Fallon pelo número 1-800-341-4848. (POR)

Внимание! Это информация о ваших льготах по плану Fallon Health MassHealth. Вам необходимо срочно ознакомиться с этой информацией. Если вам нужен перевод этой информации, Fallon может вам помочь. За помощью с переводом или любой другой помощью обращайтесь в Fallon по телефону 1-800-341-4848. (RUS)

Ważne! Niniejsze informacje dotyczą Państwa świadczeń Fallon Health MassHealth. Muszą one być natychmiast przetłumaczone. Fallon może je dla Państwa przetłumaczyć. Jeśli potrzebują Państwo pomocy w dokonaniu tłumaczenia lub pomocy w innym zakresie, proszę zatelefonować do Fallon na numer 1-800-341-4848. (POL)

Quan trọng! Thông tin này là về các quyền lợi Fallon Health MassHealth của quý vị. Cần được phiên dịch ngay, Fallon có thể phiên dịch cho quý vị. Nếu quý vị cần giúp đỡ về phiên dịch hay công việc nào khác, xin gọi cho Fallon theo số 1-800-341-4848. (VTN)



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Personal Representative Authorization Form - Accessing Personal Information

This form allows members to give Fallon Health permission to disclose their personal information to a person they designate. This person is called a Personal Representative. This form does not need to be filled out for legal representatives, such as a durable power of attorney, guardian or health care proxy. Submit a copy of this legal document to Fallon at the address listed below.

Member information

Member name:	Medicare/MassHealth number (if applicable):
Fallon member ID number:	Member Date of Birth
Member address:	Member telephone number:

Personal Representative information

Personal Representative name:	Personal Representative relationship to member:
Personal Representative address:	Personal Representative telephone number:

I give Fallon permission to disclose the following personal information to my Personal Representative (check all that apply):

- Financial information (e.g., benefits and billing information, status of a claim, and status of an authorization)
- Health care information (e.g., detailed medical and pharmacy information—such as diagnosis, procedure and prognosis—of claims, care management, and authorizations)
- Demographic information (e.g., address, date of birth, and make an address change)
- Sensitive health information (e.g., information related to treatment or diagnosis of HIV/AIDS or alcohol and drug abuse)
- Only the following information (please be specific):

My permission to disclose the personal information identified above to my Personal Representative is effective (please check one):

- From the date I sign this form until the following date _____.
- Until I cancel it in writing to Fallon at the address listed below.

- I understand that I may withdraw this permission at any time by submitting a written request to Fallon at the address listed below. I understand that it will not apply to disclosures that Fallon has made to my Personal Representative prior to me withdrawing my permission.
- I understand that state and federal privacy laws may not apply to my Personal Representative and that he/she may release my personal information.
- I understand that Fallon has not and will not condition payment, enrollment, or eligibility for benefits on me signing this form.

Member's signature: _____ Date: _____

Mail or fax completed form to:
Privacy Coordinator • Fallon Health • 10 Chestnut St. • Worcester, MA 01608
Fax 508-831-1136

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