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 Health at the address listed below.

Member information

Member name:	Medicare/MassHealth number (if applicable):
Fallon Health 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 Health 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 Health at the address listed below.

- I understand that I may withdraw this permission at any time by submitting a written request to Fallon Health at the address listed below. I understand that it will not apply to disclosures that Fallon Health 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 Health 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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