fallonhealth

Authorization for release of Protected Health Information (PHI)

Member information

Member name: _____ Date of birth: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Email address: _____

Request details

Check all applicable:

☐ I request and authorize Fallon Health to **release (give)** PHI to:

☐ I request and authorize Fallon Health to **obtain (get)** PHI from:

Name/Facility: _____

Relationship to member: _____

Address: _____

Phone number: _____ Email address: _____

Purpose of request:

☐ Care coordination ☐ At my personal request ☐ Legal request

☐ Transfer of care ☐ Other: _____

I authorize the release of the following dates of services:

from: _____ to _____

I understand if the dates above are blank, it is understood that I am authorizing all dates.

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 referenced member. If I don't approve of all medical information, I approve only the following information: _____

_____

Statutorily protected records: (Member initial all that apply)

Alcohol/drug use _____	Genetic testing _____	Sexually transmitted diseases _____
Behavioral health _____	HIV/AIDS _____	Other: _____
Domestic violence _____	Sexual assault _____	

I understand that unless otherwise revoked (taken back) or specified, this authorization is valid for 12 months from the date of my signature.

If authorizing other than 12 months, please specify the date: _____

Authorization and signature

- 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 on the previous page.
- I understand that revocation will not apply to information that has already been released.
- I understand that this information, once disclosed, may be subject to re-disclosure by the receiving entity and may no longer be protected under HIPAA or other privacy laws.
- I understand that if I have allowed the disclosure of records that identify me as having or as having had a substance use disorder, the records may be protected under 42 CFR Part 2, and may be prohibited from being re-disclosed without my express written 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 with Fallon Health.

Name (print): _____

Signature _____ Date: _____

If signed by someone other than the member, signer's relationship to member (i.e., guardian, authorized representative): _____

___ By checking here, I am authorizing my electronic signature, above, to be considered the same as my handwritten signature for the purposes of validity and enforceability. I understand that I can at any time opt to use a handwritten signature if I prefer.

Mail completed form to:
Fallon Health • 1 Mercantile St., Ste. 400 • Worcester, MA 01608