fallonhealth

Restrictions form

Member name: _____ Member ID number: _____

Member address: _____

City, State, ZIP:_____

Member telephone: _____ Member date of birth: _____

I request that Fallon Health NOT release my personal information to:

Name: _____

Address: _____

City, State, ZIP:_____

Relationship to member: _____

Telephone: _____

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

This request applies to (check all that apply):

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

I understand that my personal information may have already been released to the person/agency listed above before I requested this restriction. I may withdraw this restriction at any time by submitting a written request to the Fallon Health Privacy Officer.

Member (or personal representative) signature: _____

Relationship to member (if personal representative): _____

Print name: _____ Date: _____

Mail or fax completed form to:

Fallon Health
Attn: Privacy Officer
10 Chestnut St.
Worcester, MA 01608

Fax: 1-508-368-9934