Restrictions form

Member ID number: _____ Member name: _____

Member address: _____

Member telephone: ____-____-_____ Member date of birth: ____/____/____

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

Name: _____

Address: _____

City, state: _____ ZIP: _____

Relationship to member: _____

Telephone: ____-____-_____

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

This request applies to:

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

I may withdraw my authorization at any time by submitting a written request to Fallon Health Weinberg. 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 Weinberg
461 John James Audubon Pkwy.
Amherst, NY 14228

For Fallon Health Weinberg USE ONLY

Issued by: _____ Date sent: _____

Date received by privacy clerk: _____