Personal Representative Authorization Form

Member/Applicant Information:

First name:	Middle initial:	Last name:	
Street address:	City:	State:	ZIP code:
Date of birth:	Phone number:	Member ID number:	

To provide an Authorized Representative for the first time:
If you have not previously provided an Authorized Representative to act on your behalf and would like to do so, please provide his/her name and address:

First name:	Middle initial:	Last name:	
Street address:	City:	State:	ZIP Code:
Phone number:	Email address:		

To discontinue your authorization or to switch to someone else:
If you previously provided an Authorized Representative and would like to discontinue or change to someone new:

☐ Discontinue current Authorized Representative

First name:	Middle initial:	Last name:	
Street address:	City:	State:	ZIP Code:

☐ Designate new Authorized Representative

First name:	Middle initial:	Last name:	
Street address:	City:	State:	ZIP Code:
Phone number:	Email address:		

I understand that my designated Authorized Representative will have access to my personal health information, including information about mental health, substance use, and past and present care. I would like my Authorized Representative to (check all that apply):

- ☐ Speak with Fallon Health Weinberg about my account, including claims and billing information
- ☐ File an appeal for services on my behalf
- ☐ File a grievance on my behalf
- ☐ Other (please describe): ____

I understand this designation will remain in effect until I change or discontinue it.

____	________________________________
Signature of applicant or member	Date

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