

# AUTHORIZATION TO RELEASE MASSHEALTH OR HEALTH CONNECTOR RECORDS



Mailing Address: MassHealth Privacy Office  
One Ashburton Place, 11th Floor  
Boston, MA 02108

Email: [Privacy.Officer@mass.gov](mailto:Privacy.Officer@mass.gov)

Online: [mass.gov/info-details/masshealth-member-records-request](https://mass.gov/info-details/masshealth-member-records-request)

Member or Applicant Name: Last \_\_\_\_\_

First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_

Telephone number \_\_\_\_\_

MassHealth ID (or last 4 of SSN)

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Address: Street (include Apt #, if applicable)

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email \_\_\_\_\_

I hereby authorize MassHealth and the Health Connector to send my protected health information

To me

To this person or organization \_\_\_\_\_

Send these records by:  Mail  Secure/encrypted email

Other (specify) \_\_\_\_\_

### USE ALTERNATE EMAIL/ADDRESS

(fill this out ONLY if you want us to use a different address/email, than the address/email listed above).

Address: Street (include Apt #, if applicable)

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email \_\_\_\_\_

### INFORMATION TO BE RELEASED

**(Please select a date range)**

Claims  
(month/year) \_\_\_\_\_ to (month/year) \_\_\_\_\_

Applications  
(month/year) \_\_\_\_\_ to (month/year) \_\_\_\_\_

Notices  
(month/year) \_\_\_\_\_ to (month/year) \_\_\_\_\_

Other (specify content)  
\_\_\_\_\_

## PURPOSE OF DISCLOSURE (Please check one)

My request    Benefits    School    Legal

Other (specify) \_\_\_\_\_

CHECK IF YOU ARE REQUESTING ALCOHOL OR  
SUBSTANCE USE TREATMENT INFORMATION

I understand that I have the right to withdraw my authorization at any time. If I withdraw my authorization, it will not affect any disclosure MassHealth made when it had my permission. I understand that if I revoke this authorization, I must do so in writing. Revocations must be sent to the MassHealth Privacy Office at [privacy.officer@mass.gov](mailto:privacy.officer@mass.gov) or the mailing address listed above.

I understand that authorizing the disclosure of this health information is voluntary. My decision to use this form will have no effect on my health plan enrollment or eligibility for benefits. I understand that health information used or disclosed under this authorization may be subject to redisclosure by the recipient, and no longer protected by Federal Confidentiality regulations. However, the recipient may be prohibited from disclosing substance abuse information. I understand that I may be charged a reasonable, cost-based fee by MassHealth to produce my records.

This authorization will expire on/when \_\_\_\_\_ .

If I fail to specify an expiration date or event this authorization will expire twelve months from the date of the signature listed below, unless I revoke it earlier. I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information or medical records of my condition to those persons or agencies listed above.

Signature of Member/applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name of Legal Representative:

\_\_\_\_\_

Relationship to Member/Applicant: \_\_\_\_\_

(Proof of legal authority to act on behalf of the member is required, if not already on file with MassHealth.)