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

Online: 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)	
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 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.)

Print Clear