AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This is the only release accepted by MassHealth Disability Evaluation Services

APPLICANT: If you do not fully fill out this Authorization to Release Protected Health Information, the MassHealth Disability Evaluation Services (DES) will not be able to make a disability determination for you. You may lose or have your MassHealth benefits reduced.

Instructions

This MassHealth Authorization to Release Protected Health Information helps us get sensitive health information from your health care provider so that the MassHealth Disability Evaluation Service (DES) can make a disability determination.

Please read the instructions carefully before you fill out this form. If you leave any sections of this form blank, this permission will not be valid, and the health care provider will not be able to share your information with the MassHealth DES. If the health care provider does not share protected health information with the MassHealth DES, we will not be able to make a disability determination.

General instructions for filling out the MassHealth Authorization to Release Protected Health Information

You must follow these instructions when filling out the MassHealth Authorization to Release Protected Health Information forms. The health care providers will not send protected health information to the MassHealth DES if you do not fill out the forms the right way. We need copies of your protected health information to make a disability determination.

1. Sign and date a separate MassHealth Authorization to Release Protected Health Information form for each doctor, hospital, health center, clinic, or other health care provider you listed in Part 2 of the Disability Supplement.
2. All MassHealth Authorization to Release Protected Health Information forms must be filled out in black or blue ink and must be originals. No copies or stamps of signatures are permitted. Forms filled out and signed in pencil are not permitted.
3. Only one signature may appear on a line.
4. If this form is for a child younger than age 18, one parent or legal guardian must sign for the child.
5. Legal guardians must attach a complete copy of the document that gives them the authority to act on behalf of the applicant/member.

If you need help completing the MassHealth Authorization to Release Protected Health Information, call a DES representative at (800) 888-3420.

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This request for protected health information supports this individual's application for public benefits. Under M.G.L.c.112 § 12CC, there must be no charge for the release of the requested records. Under statute, the records must be produced within 30 days.

By filling out and signing this Authorization to Release Protected Health Information, I authorize my health care provider to share my protected health information with MassHealth Disability Evaluation Services (DES). This form will allow my doctors to share my protected health information with MassHealth (DES) to determine my eligibility for disability services.

- I understand that some information used or shared as part of this authorization could be re-shared by DES. If so, it may not be subject to federal or state law protecting its confidentiality.
- I also understand that certain health information has special protections for sensitive information. This health information includes records about HIV infection, AIDS, genetic testing, and psychological or psychiatric conditions. This health information is protected under state and federal law and cannot be shared without my written consent unless otherwise

allowed by law. 42 CFR part 2 does not allow a program that provides substance use disorder diagnosis, treatment, or referral for treatment to share health information that it creates, receives, or acquires about me without my authorization.

SECTION 1:
MassHealth Applicant/Member Information

Name _____

Date of Birth ____ /____/_____

Street address _____

City, State, Zip _____

Telephone Number (_____) _____

SECTION 2:
Healthcare Provider Information

Name of doctor, health center, or other health care provider _____

Street address _____

City, State, Zip _____

Telephone Number (_____) _____

SECTION 3:
Sensitive Medical Information to be Shared with DES

I authorize the release of my entire medical record.
Check YES or NO for EACH of the following options.

☐ Yes ☐ No Mental or Psychiatric Health Information

☐ Yes ☐ No HIV, AIDS, Sexually Transmitted Disease Information

☐ Yes ☐ No Genetic Testing. See MGL c. 111 § 70G

☐ Yes ☐ No Substance Use Information

☐ Yes ☐ No Other (please specify):

_____

This authorization is good from 12 months before the signature date through its expiration. This authorization expires 12 months from the signature date.

Signature of Applicant/Member or Legal Representative

_____ Date ___ / ___ / _____

Relationship to Applicant/Member or authority to act for Applicant/Member _____
Date ___ / ___ / _____

Please attach a complete copy of the document that gives this person the authority to act on behalf of the applicant/member.

Unless action has already been taken in reliance upon it, or during a contestability period under applicable law, I understand that I may revoke this authorization at any time by sending a written request to DES, PO Box 2796, Worcester, MA 01613. This authorization expires one (1) year from the signature date.