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, 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 health information from your health care provider so that DES can make a disability decision.

Please read the instructions carefully before you begin. If you leave any sections of this form blank, or do not fill out the form the right way, the permission will not be valid. Your health care provider will not be able to share your protected health information with DES.

- Sign and date a **separate** Authorization to Release Protected Health Information form for **each** doctor, hospital, health center, clinic, or other health care provider you listed in the Disability Supplement.
- All Authorization to Release Protected Health Information forms must be filled out in black or blue ink and must be originals. Forms filled out and signed in pencil are not permitted. No copies or stamps of signatures are permitted. Electronic signatures are acceptable.
- Only one signature may appear on a line.
- Emailed, faxed, and mailed releases are accepted with valid signature.

- If this form is for a child younger than 18, one parent or legal guardian must sign for the child.
- Legal guardians must attach a complete copy of the form that gives them the authority to act on behalf of the applicant.

If you need help completing the 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 Disability Evaluation Services (DES). This form will allow my doctors to share my protected health information with 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. If the information is re-shared, it may no longer be protected by federal or state confidentiality laws.
- I also understand that certain sensitive health information has special protections. This sensitive health information includes records about HIV infection, AIDS, genetic testing, and psychological or psychiatric conditions. This sensitive 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 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

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

Street address _____
Floor # _____ Suite # _____
City, State, Zip _____

Telephone number (_____) _____

SECTION 3:
Sensitive Medical Information to Be Shared with DES

Please check YES to indicate your permission to release the following information if present in your record.

☐ Yes Mental or Psychiatric Health Information

☐ Yes HIV, AIDS, Sexually Transmitted Disease Information

☐ Yes Genetic Testing. See MGL c. 111 § 70G

☐ Yes Substance Use Information

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 or Legal Representative

_____ Date ___ / ___ / _____

Relationship to Applicant or authority to act for Applicant _____

If this form is being completed by a legal representative, please attach a complete copy of the document that gives you the authority to act on behalf of the applicant.

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 Disability Evaluation Services, PO Box 2796, Worcester, MA 01613.