**MASSACHUSETTS COMMISSION FOR THE DEAF AND HARD OF HEARING**

**40 Broad Street**

**Boston, MA 02109**

**Community Services Division**

**Referral Form**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name:**  Click or tap here to enter text. | | | | **Date of Referral:**  Click or tap here to enter text. | | |
| **Parent(s)/Guardian(s) Name(s):**  Click or tap here to enter text. | | | | | | |
| **Address:**  Click or tap here to enter text. | | | **City/Town:**  Click or tap here to enter text. | | | **Zip Code:**  Click or tap here to enter text. |
| **Phone/VP#:**  Click or tap here to enter text. | | **Email Address:**  Click or tap here to enter text. | | | | |
| **Hearing Status:**  Click or tap here to enter text. | | | | **Preferred Language:**  Click or tap here to enter text. | | |
| **Date of Birth:**  Click or tap here to enter text. | **Gender:**  Click or tap here to enter text. | | | | **MassHealth: Yes  No** | |

|  |
| --- |
| **Reason for Referral:** Click or tap here to enter text. |

|  |  |
| --- | --- |
| **Party Making this Referral (i.e. Agency, Individual, Self):**  Click or tap here to enter text. | |
| **Contact Person:**  Click or tap here to enter text. | |
| **Contact Phone #:**  Click or tap here to enter text. | **Contact Email Address:**  Click or tap here to enter text. |

**Please send all forms to the Community Services Mailbox at:** [**MCDHH-CommServDiv@mass.gov**](mailto:MCDHH-CommServDiv@mass.gov) **also include a signed Release of Information form if available and any pertinent information, i.e., discharge plans, evaluation/assessment reports, other pertinent reports, and/or pertinent case notes.**

**If there are any questions pertaining to making referrals please contact the Community Services Division at Massachusetts Commission for Deaf and Hard of Hearing.**

**(617) 740–1600 (Voice) or (617) 326-7546 (Video Phone)**

A picture containing text

Description automatically generated

**KIAME MAHANIAH, MD, MBA**

SECRETARY

**DR. OPEOLUWA SOTONWA**

COMMISSIONER

**VOICE** (617) 740-1600

**VP** (617) 326-7546

**TTY** (617) 740-1700

**VOICE** (800) 882-1155

**TTY** (800) 530-7570

**FAX** (617) 740-1810

MA COMMISSION FOR THE DEAF AND HARD OF HEARING

**COMMONWEALTH OF MASSACHUSETTS**

40 BROAD STREET, BOSTON, MA 02109

MASS.GOV/MCDHH

**MAURA T. HEALEY**

GOVERNOR

**KIMBERLEY DRISCOLL**

LIEUTENANT GOVERNOR

# COMMUNITY SERVICES DIVISION

## Release of/Request for Information

|  |  |  |  |
| --- | --- | --- | --- |
| I, |  |  | give permission for copies of records and |

(Client/Consumer’s Name)

Information to be released and/or shared (in communication over the telephone or in meetings)

|  |  |
| --- | --- |
| between |  |
|  | |
|  | |

(Names of Individuals and/or Agencies)

and the Massachusetts Commission for Deaf and Hard of Hearing (MCDHH).

|  |  |
| --- | --- |
| No information may be released to |  |
|  | |
|  | |

(Names of Individuals and/or Agencies)

I understand that all information will be kept confidential, and I have the right to withdraw my

permission at any time by giving written notice to MCDHH. This Release of Information will expire one year from the date of the client/consumer’s signature. MCDHH staff are allowed to work with other MCDHH departments on your behalf.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Client/Consumer Signature |  | Date |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| (Signature of Parent if Client/Consumer is Under Age 18, or Signature of Court Appointed Guardian) |  | Date |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of MCDHH Staff |  | Date |