
LETTERHEAD OF PROVIDER AGENCY

Release of Client/Confidential Information Authorization to Release Information To

*Enterprise Invoice Management/Enterprise Service Management (EIM/ESM)
The Department of Public Health*

I understand that in order to provide me with appropriate services and treatment, <insert name of Provider Agency> must collect my enrollment information which may include name, address, social security number, and date of birth and other records including my medical history, assessment and treatment services received. By signing this release I am authorizing <insert name of Provider Agency> to give identifiable information about me to the Bureau of Substance Addiction Services (BSAS) of the Massachusetts Department of Public Health (Department), which licenses and/or funds this program. I understand BSAS takes many steps to protect the privacy and security of information that it receives. I also understand that my treatment records are protected under federal law, 42 C.F.R., Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, and by state law, and cannot be disclosed by <insert name of Provider Agency> to BSAS without my approval, unless permitted by law. Access to this information will be limited to authorized staff of BSAS, and may be used by BSAS, for example, to:

- Review my services
- Determine how effective the services are
- Assess the overall program in which I am enrolled
- Plan and support future programs
- Meet federal and/or state reporting requirements to continue funding
- In some cases, pay for services I receive

I understand that when used in analysis across programs, data from my record will be kept anonymous and I will not be identified. No information that identifies me will be connected with any reports that are released outside the Department.

Once I have agreed to this release of my information, I still have the right to cancel this authorization by submitting a written request at any point during my treatment at the Program to

_____ at _____
Name Address

Once my cancellation request has been received, no further information identifying me will be released to BSAS; however I understand that this cancellation will not apply to information already released. This authorization will expire automatically thirty (30) days after I am no longer enrolled in this program or as otherwise specified: _____

Specify a date/event/condition

I also understand in general that I cannot be denied services if I choose not to sign this authorization.

By signing below, I indicate that I understand and agree to the request for the release of my Program information to BSAS.

I, _____ give permission for <insert name of Provider Agency>
Name (please print)

to release the information described above to the BSAS.

Dated: _____ Signature of Client/Student _____

Signature of Client, Parent or Guardian

Signature of Witness (if required)

Pursuant to the Federal Privacy Act of 1974 at 5 U.S.C. § 552a, you are hereby notified that disclosure of your social security number is voluntary. Disclosure of the social security number is requested pursuant to MGL c 111 E, MGL c 111 B, 42 CFR Part 2, 105 CMR 164, Ch. 208 of the Acts of 2018, and MGL c 111 § 237. The social security number is used for client indexing, identity verification, and payment reconciliation.