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MassHealth ABI/MFP Waiver Medical Records Release Form

Evaluation for MassHealth Waiver Benefits

This Medical Records Release Form is for the MassHealth Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) waivers. The purpose of this form is to get permission for your health care providers to release your medical information. The ABI/MFP Waiver Clinical Eligibility Unit will use this information to see if you are eligible for the ABI or MFP waiver that you are applying for. If you are eligible, the Massachusetts Department of Developmental Services (DDS) and MassAbility will use this medical information to plan and coordinate your waiver benefits.

Instructions for Filling Out the Medical Records Release Form

Please read these instructions carefully. We need copies of your medical records to see if you are eligible for a waiver. If you leave any sections blank, your health care providers may not share information with the ABI/MFP Waiver Clinical Eligibility Unit and we won't be able to decide if you are eligible for the ABI or MFP waiver that you are applying for. Here's what you need to know to send in this form.

1. Sign and date this MassHealth ABI/MFP Waiver Medical Records Release Form.
2. All signatures must be in ink and must be originals. No copies or stamps of signatures are allowed. Electronic signatures are acceptable.
3. Only one signature may appear on a line.
4. Send this form to

Email:
ABIinfo@umassmed.edu
or MFPinfo@umassmed.edu

Fax:
(508) 856-7754
or (855) 899-7754

Mail:
Waiver Unit
UMass Chan Medical School
PO Box 2635
Worcester, MA 01613

SECTION I

I give permission for the health care providers I listed in Section 2 to share the medical information I listed in Section 3 about ..... with the ABI/MFP Waiver Clinical Eligibility Unit.
(Please print name of applicant or member).

(Please note that **you must provide your signature in Section 5** for your health care providers to share your medical information.)

SECTION 2

Please print the name of the health care providers that may share your medical information with the ABI/MFP Waiver Clinical Eligibility Unit. **If you want more than three health care providers to share medical information, please fill out a second release form or contact us for an additional form.**

Health care provider #1

Name of doctor, health center, or other health care provider:	
Street address:	
City, state, ZIP code:	Phone:

Health care provider #2

Name of doctor, health center, or other health care provider:	
Street address:	
City, state, ZIP code:	Phone:

Health care provider #3

Name of doctor, health center, or other health care provider:	
Street address:	
City, state, ZIP code:	Phone:

SECTION 3

The health care providers listed in Section 2 may share the following information with the ABI/MFP Waiver Clinical Eligibility Unit to determine eligibility for ABI/MFP Waivers. If you are eligible, we may also share this information with DDS and MassAbility for care planning and care coordination of waiver benefits.

All medical records or other information about your treatment, hospitalization, and/or outpatient care for conditions including

- mental or psychiatric health information
- HIV/AIDS/sexually transmitted disease information
- genetic testing (See M.G.L. c. 111 § 70G.)
- how impairments affect activities of daily living and ability to work
- substance use information
- other (please discribe):

Check here if you do not want the health care provider to share information about your

- ☐ HIV/AIDS/sexually transmitted disease information
- ☐ genetic testing (See M.G.L. c. 111 § 70G.)

SECTION 4

Any medical information that your health care providers give to the ABI/MFP Waiver Clinical Eligibility Unit will continue to be protected by federal privacy laws.

This permission to share medical information with the ABI/MFP Waiver Clinical Eligibility Unit ends 12 months from the date you sign this release form, unless you have cancelled permission in writing before then.

I understand that I may cancel this permission at any time by sending a letter to the health care providers I listed in Section 2.

I understand that even if I cancel this permission, the health care providers I listed in Section 2 can't take back any information that was shared with the ABI/MFP Waiver Clinical Eligibility Unit when the health care providers had my permission to do so.

I understand that my decision to give the health care providers permission to share medical information for the purposes of MassHealth ABI/MFP Waiver benefits is voluntary. I also understand that this information will **not** be used to see if I am eligible for MassHealth Waiver benefits or for MassHealth Waiver care planning and care coordination **if I do not sign in Section 5 below** to give permission to the health care providers to share my medical information.

SECTION 5

Signature of applicant/member:	Date:	
Print name of applicant/member:	Date of birth:	
Street address:	Phone:	
City/Town:	State:	ZIP code:

If this form is being filled out by someone who has the legal authority to act on behalf of the applicant/member (such as an eligibility representative or a legal guardian), please fill out the following information.

Signature of person filling out this form:	
Print name:	Date:
Authority of person filling out this form to act on behalf of the applicant/member: Please include a copy of the document that gives this person the authority to act on behalf of the applicant/member.	

The ABI/MFP Waiver Clinical Eligibility Unit will send you a copy of this signed Medical Records Release Form for you to keep for your records. You can also request another copy of this signed Medical Records Release Form at any time by contacting the ABI/MFP Clinical Eligibility Unit at the following address.

Waiver Unit
UMass Chan Medical School
PO Box 2635
Worcester, MA 01613