

# 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 medical information from your health care providers. The ABI/MFP Waiver Clinical Eligibility Unit can use this information to determine your eligibility for the ABI or MFP waiver that you are applying for. If you are eligible, the Massachusetts Department of Developmental Services and the Massachusetts Rehabilitation Commission can use this medical information for care planning and care coordination of your waiver benefits.

## General Instructions for Filling Out the Medical Records Release Form

Please read the instructions carefully. We need copies of your medical records to confirm your Waiver eligibility. If you leave any sections blank, your health care providers may not share information with the ABI/MFP Waiver Clinical Eligibility Unit to determine your eligibility for the ABI or MFP waiver that you are applying for. We also won't be able to share it with the Massachusetts Department of Developmental Services and the Massachusetts Rehabilitation Commission for care planning and care coordination of your waiver benefits.

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.
3. Only one signature may appear on a line.

## SECTION I

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

## SECTION II

Please print the name of the health care providers that may share 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.

### Health care provider #1

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

### Health care provider #2

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

### Health care provider #3

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

### SECTION III

The health care providers listed in Section II 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 the Massachusetts Department of Developmental Services and the Massachusetts Rehabilitation Commission for care planning and care coordination of waiver benefits.

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

- psychological/psychiatric impairments
- AIDS/HIV
- how impairments affect activities of daily living and ability to work
- drug and alcohol use
- other (please describe):

Check here if **you do not want** the health care provider to share information about AIDS/HIV status

### SECTION IV

**Any medical information that the health care provider gives 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 twelve 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 II.

I understand that even if I cancel this permission, the health care providers I listed in Section II 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 demonstrate my eligibility for MassHealth Waiver benefits or for MassHealth Waiver care planning and care coordination if I do not give permission to the health care providers to share medical information.

### SECTION V

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

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 give us 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 give us 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 return to 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.

ABI/MFP Waiver Clinical Eligibility Unit  
Disability and Community-based Services  
Commonwealth Medicine  
University of Massachusetts Chan Medical School  
333 South Street  
Shrewsbury, MA 01545