PERMISSION TO SHARE INFORMATION (PSI) FORM

Use this form if you want to give MassHealth or the Health Connector permission to talk with another person or organization about your eligibility and share copies of your eligibility notices.

- a family member, friend, or other trusted person,
- someone who helps take care of you,
- someone who helps you fill out MassHealth or Health Connector forms, or
- a social worker, lawyer, or health care advocacy group.

Do not use this form if you want

- to give another person or organization permission to make changes to your MassHealth application;
- information about yourself or copies of your own records (go to www.mass.gov/info-details/masshealth-member-records-request.)
  - You can also access your own eligibility information, including notices, applications, and renewals, if you have a MA Login or MyServices account on mass.gov.;

- information about your children younger than 18 (You can usually get this without a form);
- your information to be shared with your health care provider (Your health care provider can get your information without a form); or
- to appoint an appeal representative for a Fair Hearing (Fill out the appropriate sections on the Fair Hearings Request (FHR-1) form OR complete a current Authorized Representative Designation (ARD) form).

Important: If you decide you want to fill out this form, you must fill out all applicable sections and fields, unless marked otherwise. Print clearly and remember to sign and date Section 4. If a legally appointed representative completes this form, they must sign and date Section 4.

For more information about how MassHealth uses and discloses your information, see our MassHealth Notice of Privacy Practices at: www.mass.gov/doc/masshealth-notice-of-privacy-practices/download

SECTION 1

Name of applicant or member

I give permission for MassHealth, the Health Connector, and its representatives to share the information listed in **Section 2** about

Name of applicant or member whose information is to be shared

_____

Street _____ City _____

State _____ Zip _____

Date of birth _____

Telephone number (optional) _____

MassHealth ID (or last 4 of SSN)

__ __ __ __ __ __ __ __ __ __ __ __ (if you have one)

Please Note: Fields with an asterisk * are required. If you do not have a MassHealth ID number, you can give us the last four digits of your social security number (SSN), if you have one.

SECTION 2

Permission for MassHealth and the Health Connector to talk about your eligibility details and share copies of your eligibility notices

The person or organization that you write in **Section 3** will be able to contact MassHealth and the Health Connector to receive information described by the checked box below.

☐ I give MassHealth permission to do the following:

- talk about my MassHealth or Health Connector case, and
- share copies of eligibility notices with the person or organization written in **Section 3**.

Note: If you check this box, MassHealth and the Health Connector will send copies of your eligibility notices to the person or organization in Section 3. They can request copies of your eligibility notices. These notices may contain financial information and have information about some or all members of the household.

Members of your household who are 18 or older will have to complete and sign a separate PSI form if they want their specific eligibility notices sent to them.

Do you also give MassHealth and the Health Connector permission to share details about drug and alcohol treatment?

☐ Yes ☐ No

Why do you want to share this information?

Tell us why you want to share the information listed in this section. If you leave the section blank, we will assume you mean "at my request."

If you have given MassHealth and the Health Connector permission to share your drug and alcohol treatment information for purposes of payment or health care operations activities, the recipient is permitted to further disclose your drug or alcohol treatment information to its contractors, subcontractors, or legal representatives to carry out payment or health care operations on its behalf.

SECTION 3

Whom do you want us to share information with?

Write the name of ONLY ONE person or organization in this section. You must fill out another PSI form if you want to name more than one person or organization.

MassHealth and the Health Connector may share the information listed in **Section 2** with

Name of person or organization

_____

In care of (name of person in organization to whom mail should be sent) _____

_

Street _____ City _____

State _____ Zip _____

Telephone number (optional) _____

Email (optional) _____

End of permission: This PSI will end in 12 months unless you write a different date here.

DATE: _____

Note: This PSI will end upon the death of the member listed in Section 1 if it is before the date provided above.

SECTION 4

Signature of Applicant or Member, or their Legally Appointed Representative

I understand and certify the following.

- When the person or organization named in **Section 3** gets this information from MassHealth or the Health Connector, they may be able to share it with others without my permission. If they share that information, federal and state privacy laws may not protect the information.
- I need to submit this PSI using one of the ways listed in **Section 5**.
- I may cancel this permission at any time by sending a letter to:
  Health Insurance Processing Center
  PO Box 4405
  Taunton, MA 02780
- MassHealth, the Massachusetts Health Connector, and the Health Safety Net, in connection with the eligibility and enrollment process, may send notices that contain personal information about the people listed on my application to the person or organization named in **Section 3**, or otherwise communicate such information to them. This information may include records or data about people listed on my application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources, including financial institutions. This information can be used 1) to prove

any information given on my application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.

- I have told or will tell anyone listed on this application (or their parent or legally authorized representative, if applicable) about the duties, responsibilities, and access to information the person or organization named in **Section 3** will have so they understand them.
- If I cancel this permission, MassHealth or the Health Connector cannot take back any information that it shared while it had my permission.
- My decision to use this form will not affect my MassHealth or Health Connector benefits any way.
- In certain circumstances, MassHealth and the Health Connector may not be able to share information.
- This request can be withdrawn at any time by the member, the authorized person, or the organization.

Name of applicant or member (please print)

_____

Printed name of person filling out this form, if not the applicant or member _____

Authority of person filling out this form to act on behalf of the applicant or member _____

Signature of applicant or member, or their legally appointed representative _____

Date _____

A legally appointed representative is someone that has been granted the authority to act on behalf of the applicant or member and has legal documentation to prove it. If this form is being completed by someone who is a legally appointed representative (such as a parent of a minor child, an authorized eligibility representative, or a legal guardian appointed by a court or power of attorney), a copy of the applicable legal document must be attached.

SECTION 5
Submit this Form

Mail your form to:

Health Insurance Processing Center
PO Box 4405
Taunton, MA 02780

Fax your form to: (857) 323-8300

Submit your form in person at the MassHealth Enrollment Centers.