Massachusetts Department of Public Health
Authorization for Release of Information
Permission to Share Information

If you want the Prescription Monitoring Program to share information about you with another person or organization, please make sure that you fill out all of the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section II (B), your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

(Fill in name of person or organization)

SECTION I

I, _____, give my permission for MDPH Prescription Monitoring Program
(print your name) (Fill in name of person or organization)
to share the information about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II

A. Health and Personal Information MDPH Prescription Monitoring Program

Please describe the information you want the _____ to share about you.
(Fill in name of person or organization)

Please include any dates and details you want to share.

A 1 year back report of my PMP prescription history, delivered (1) immediately upon receiving this request and (2) quarterly thereafter until this permission ends, 1 year after the date of the execution of this form.

Please deliver to PSUD Supervisor.

B. Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

_____I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

____I specifically give permission, as required by M.G.L. c. 111, §70G, to share information in my record about my genetic information.

__X__I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION III – Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request," if you are initiating the request.

At my request.

SECTION IV – Who May Share This Information

I give permission to the person or organization listed below to share the information I listed in Section II:

David Johnson - MDPH PMP Director
Name

MDPH Prescription Monitoring Program
Organization

239 Causeway Street, Boston MA 02114
Address

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SECTION V – Who May Receive My Information

The person or organization listed in Section IV may share the information I listed in Section II with this person(s) or organization:

Edmund Taglieri - PSUD Supervisor

Name

Pharmacy Substance Use Disorder Program

Organization

MDPH - Board of Pharmacy

Address

239 Causeway Street - 5th Floor - Boston MA 02114

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION VI – How Long This Permission Lasts

This permission to share my information is good until 1 year from the date of signature.

Indicate date or event

If I do not list a date or event, this permission will last for one year from the date it is signed.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to David Johnson - PMP Director, and send it or bring it to the place where I am now giving this permission (or fill in specific location). If the information has already been given out by, I understand that it is too late for me to change my mind and cancel the permission.

  (Fill in name of person or organization)

- I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section V.

- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION V – Signature

Please sign and date this form, and print your name.

Your Signature _____ Date _____

Print Your Name _____

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Describe how this person has legal authority for this individual: _____