Commonwealth of Massachusetts
MassAbility

Authorization for Release of Information

Overview: MassAbility is an agency under the Executive Office of Health and Human Services (EOHHS), that provides services to people with disabilities. These services sit under three main groups: The Career Services Division, the Community Living Division, and Disability Determination Services.

This release form will provide access to the information we need to help determine if you are eligible for our services, and what services are the best fit for you.

Specify the purpose for this authorization (check all that apply):

☐ Service Planning ☐ Determine eligibility for services ☐ Referral
☐ Coordinate care ☐ Obtain insurance, financial, or other benefits
☐ Other purpose, please specify: _____

Please provide the following information:

Legal Name: _____ Preferred Name: _____

Previous Names: _____ Phone: _____

Address: _____ Alternate Phone: _____

City, State, Zip: _____ Date of Birth: _____

Email: _____

Social Security #: _____ MassHealth #: _____

Who will have access to my information? By signing this document, I agree to share my information with: (1) MassAbility (2) Other agencies run by the Executive Office of Health and Human Services including the Department of Transitional Assistance, the Department of Mental Health, the Department of Children and Family Services, Department of Public Health, MassHealth, the Commissioner for the Deaf and Hard of Hearing, Department of Developmental Services, Commission for the Blind, Department of Veterans Services, and Soldiers' Home, and (3) the Massachusetts Executive Office of Elder Affairs, and (3) with workforce development partners.

The following state agencies <u>do not</u> have my permission to access or share my information (if none write N/A): _____

How will my information be used? My information will be used to determine if I'm eligible for services and what services fit my needs, and this information would be shared only if necessary for program administration and service delivery. The information shared may include written documents and conversations between MassAbility staff. Once my information is shared, it may no longer be protected by federal or state privacy laws or regulations.

Volunteering Information: Sharing my information is my choice. I do not have to sign this form to receive services. However, without this information, MassAbility may be unable to provide helpful and appropriate care for me.

How long does this approval last? This release will expire in 12 months from the date listed with my signature, unless I specify a different time or date here: _____

What if I want to revoke this approval? I have a right to revoke this approval at any time. If I want to revoke this approval, I must put it in writing and give a copy to the person, facility or agency that requested this release. The withdrawal would not apply to information that has already been shared.

When can MassAbility share my information without my permission?

- In order to protect you or the public, where this is a threat to either yourself or others;
- In response to investigations in connection with law enforcement, fraud, or abuse, unless expressly prohibited by Federal or State laws or regulations, and in response to a judicial order;
- Release for audit, evaluation, and research; or
- If required by Federal/State law or regulations, unless otherwise prohibited.

Specify information you agree to be shared:

My Entire Record ☐ **OR**

Check all that apply below:

Assessment & Tests	☐	Consultations	☐	Evaluations	☐
Functional Abilities Assessment	☐	Provider Records & Reports	☐	Summary of services	☐
Verbal exchange of information	☐	Vocational Rehab Records	☐	Service plans	☐
Neuropsychology / Neurology	☐	Psychological Evaluations	☐	Medical Record	☐
Statewide Head Injury Records	☐	Vocational Evaluations	☐	Home Care Records	☐
Shared Living Records	☐	Supported Living Records	☐	ABI/MFP Waiver Records	☐
Admission(s) Notes	☐	Treatment Plans	☐	Progress Notes	☐
Discharge Summaries	☐	OT / PT / Speech	☐	School Records	☐
Other – specify:	☐	_____			

Specially Authorized Releases of Information ***(please check all that apply)***

☐ **By checking this box**, I agree to share any alcohol or drug treatment information (protected under Federal law) included in my medical record.

☐ **By checking this box,** I agree to share any HIV antibody and antigen testing (protected by Massachusetts state law), or an HIV/AIDS diagnosis or treatment included in my medical record.

Your signature or Personal Representative's signature: _____

Date: _____

Print name of signer: _____

If signed by a personal representative, type of authority (e.g., court appointed guardian, custodial parent): _____

INSTRUCTIONS:

1. Print this form to be double sided.
2. This form must be completed in full to be considered valid.
3. Distribution of copies: send original copy to appropriate MassAbility record; copy to individual or Personal Representative.
4. This form can be mailed, faxed, or emailed as an attachment

A copy of this authorization shall be considered as valid as the original.