MassHealth

Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

MassHealth Medical Records Release Form

MassHealth Disability Evaluation Service

This MassHealth Medical Records Release Form is to get medical information from your health-care provider so that the MassHealth Disability Evaluation Service (DES) can make a disability determination.

Please read the instructions carefully before you fill out this form. If you leave any sections of this form blank, this permission will not be valid, and the health-care provider will not be able to share your information with the MassHealth DES. If the health-care provider does not share medical information with the MassHealth DES, we will not be able to make a disability determination.

General instructions for filling out the Medical Records Release Form

You must follow these instructions when filling out the Medical Records Release Forms. The health-care providers will not send medical records to the MassHealth DES if you do not fill out the forms the right way. We cannot make a disability determination without copies of medical records.

1. Sign and date a Medical Records Release Form for each doctor, hospital, health center, clinic, or other health-care provider you listed in the Disability Supplement.
2. All signatures must be in ink and must be originals. No copies or stamps of signatures are permitted.
3. Only one signature may appear on a line.
4. If this form is for a child under age 18, one parent or legal guardian must sign for the child.

SECTION I

Permission is given for the health-care provider listed in Section II to share the medical information listed in Section III about

_____ with the MassHealth DES.

(Please print name of applicant or member.)

SECTION II

Please print the name of the health-care provider that may share medical information with the MassHealth DES.

Name of doctor, health center, or other health-care provider:
Street address:
City, state, zip:
Telephone number: ( )

SECTION III

The health-care provider listed in Section II may share the following information with the MassHealth DES to determine eligibility for MassHealth benefits.

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

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

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

Check here **if you do not want** the health-care provider to share information about drug or alcohol use. ☐

(continued on back) ▶

SECTION IV

Any medical information that the health-care provider releases to the MassHealth Disability Evaluation Service will continue to be protected by federal privacy laws.

This permission to release medical information to the MassHealth Disability Evaluation Service ends six 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 provider I listed in Section II.

I understand that even if I cancel this permission, the health-care provider I listed in Section II cannot take back any information that it shared with the MassHealth Disability Evaluation Service when it had my permission to do so.

I also understand that my decision whether to give the health-care provider permission to share medical information with the MassHealth Disability Evaluation Service is voluntary. However, I also understand that if I do not give permission to the health-care provider to share medical information with the MassHealth Disability Evaluation Service, the MassHealth Disability Evaluation Service will not be able to make a disability determination, and the decision about eligibility for MassHealth benefits will be made without consideration of any disability claimed.

SECTION V

Signature of applicant/member:		Date:
Print name of applicant/member:		Tel no.: ( )
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 the parent of a minor child, an eligibility representative, or a legal guardian), 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.	

MassHealth will send you back 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 MassHealth at the following address.

MassHealth
Privacy Office
600 Washington Street
Boston, MA 02111