



Commonwealth of Massachusetts
Division of Medical Assistance
www.mass.gov/dma

MASSEALTH PERMISSION TO SHARE INFORMATION FORM

If you want the Division of Medical Assistance to share information about you with another person or organization, please make sure that you fill out all of the numbered sections below to tell us whom to share your information with and what information you want us to share. If you leave ANY sections blank, your permission will not be valid, and the Division of Medical Assistance will not be able to share your information with the person or organization you listed on this form.

SECTION I

Permission is given for the Division of Medical Assistance and its representatives to share information listed in SECTION II about

_____ with the person or organization listed in SECTION III.
(name of MassHealth applicant or member)

SECTION II

The Division of Medical Assistance may share this information. (Check all that apply.)

- Eligibility notices and information about eligibility for and access to MassHealth benefits
- Status and notices about disability determination
- Other: (please be specific) _____

By giving the Division of Medical Assistance permission to share the information listed above, I am specifically giving permission to share any information about drug and alcohol treatment that is included in that information.

SECTION III

The Division of Medical Assistance may share the information listed in SECTION II with this person or organization:

Name of person or organization:
Street address:
City, state, zip:
Telephone number: ()

SECTION IV

The Division of Medical Assistance may share the information listed in SECTION II for the following reasons: (Please note: If you do not want to list reasons, you may simply write: "at my request.")

SECTION V

This permission to share information is good until _____

SECTION VI

I understand that:

- ◆ the person or organization listed in **SECTION III** may be able to further share the information that the Division of Medical Assistance gives them. If they do, federal and state privacy laws may not protect the information;
- ◆ I may cancel this permission at any time by sending a letter to:

Division of Medical Assistance
Privacy and Security Office
600 Washington Street
Boston, MA 02111;
- ◆ the Division of Medical Assistance cannot take back any information that it shared when it had my permission to do so;
- ◆ if I do not give the Division of Medical Assistance permission to share information, or if I cancel my permission to share information with the person or organization listed in **SECTION III**, MassHealth benefits will not be affected in any way; and
- ◆ in certain circumstances, the Division of Medical Assistance may not honor my request to share information.

Signature of applicant/member:	Date:
Print name of applicant/member:	
Applicant/Member SSN:	Applicant/Member date of birth:

(Please Note: The applicant's or member's SSN is required if one has been issued, unless he or she is only applying for or getting MassHealth Limited or Children's Medical Security Plan (CMSP) benefits.)

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:

Print name of person filling out this form:	
Signature of person filling out this form:	Date:
Authority of person filling out this form to act on behalf of the applicant/member:	