

Fill out the following section 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).

Print name of person filling out this form:

Signature of person filling out this form:

Date: ____/____/____

Address: _____

Telephone number: _____-_____-_____

*Authority of person filling out this form to act on behalf of the applicant/member:

*If this form is being filled out by someone who has been appointed by a court as a legal guardian or conservator, or who has power of attorney or health-care proxy, **a copy of the applicable legal document must be attached.**

Send the filled-out MassHealth Permission to Share Information (PSI) Form to the MassHealth Enrollment Center (MEC) closest to you:

Revere MEC
300 Ocean Ave.
Suite 4000
Revere, MA 02151

Springfield MEC
333 Bridge St.
Springfield, MA 01103

Taunton MEC
21 Spring St.
Suite 4
Taunton, MA 02780

Tewksbury MEC
367 East St.
Tewksbury, MA 01876



MassHealth Permission to Share Information (PSI) Form

Use this form if you want MassHealth to share the information we have about you with another person or organization, such as:

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

Do not use this form if you want:

- information about yourself;
- information about your children under age 18 (You can usually get this without filling out any forms.); or
- your eligibility and payment information to be shared with your health-care provider. (Your health-care provider can get information about your MassHealth eligibility and payment for services provided to you without you filling out any forms.)

Important: If you decide that you **do** need to fill out this form, **you must fill out all sections completely. Please print clearly.**

Section 1: Name of MassHealth Applicant or Member

Permission is given for MassHealth and its representatives to share information listed in **Section 2** about:

(Name of applicant or member whose information is to be shared)

Address: _____

Date of birth: ____/____/____

Telephone number: _____ - _____ - _____

Social security number: _____ - _____ - _____

with the person or organization listed in **Section 3**.

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

Section 2: What Information Do You Want Shared?

Check the box or boxes that apply. Please read carefully.

I am giving MassHealth permission to share:

- eligibility notices and information about eligibility for, and access to, MassHealth benefits with the person or organization listed in Section 3.** (Check this box only if you want the person or organization in **Section 3** to be able to contact MassHealth to get eligibility information and copies of your eligibility notices.)

Please Note: Eligibility notices include information about all members of a household. If you check this box, a separate PSI Form must be submitted and signed by each member of your household who is 18 years of age or older. If we do not get forms signed by each member of your household who is 18 years of age or older, we will not be able to honor your request.

- information about the status of my disability determination and notices about my disability determinations.** (Check this box only if you have submitted a MassHealth Disability Supplement and are waiting for a determination of your disability.)

- only the following information (please be specific):**

By giving MassHealth this permission to share information, are you also giving MassHealth permission to share any drug and alcohol treatment information it has about the applicant or member?

- Yes, share drug and alcohol treatment information.**
- No, do not share drug and alcohol treatment information.**

Section 3: Whom Do You Want Us to Share Information With?

List 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 may share the information listed in **Section 2** with:

Name of person or organization:
Network Health

In care of (name of person in organization to whom mail should be sent):
Dhana Luna / WS09

Address: 101 Station Landing, Fourth Floor,
Medford, MA 02155

Telephone number: 888 - 257 - 1985

Fax number: _____ - _____ - _____

Section 4: Why Do You Want Us to Share Your Information?

Tell us why you want to share the information listed in **Section 2**. If you do not want to list reasons, write: "at my request." If you leave this section blank, we will assume you mean "at my request."

I am giving MassHealth my permission to share the information listed in Section 2 because:

Section 5: End of Permission

This Permission to Share Information is good until:

____/____/____

If you do not put a specific end date, this permission will end 12 months from the date we get this form.

Section 6: Signature

I understand that:

- when the person or organization named in **Section 3** gets this information from MassHealth, that person or organization may be able to share it with others without my permission. If they do so, federal and state privacy laws may not protect the information;
- I need to send this PSI Form to the MassHealth Enrollment Center (MEC) (listed on the back of this form) closest to where I live;
- I may cancel this permission at any time by sending a letter to:

MassHealth
Privacy and Security Office
600 Washington Street
Boston, MA 02111;
- if I cancel this permission, MassHealth cannot take back any information that it shared when it had my permission to do so;
- if I do not give MassHealth permission to share information, or if I cancel my permission to share information with the person or organization named in **Section 3**, the applicant's or member's MassHealth benefits will not be affected in any way; and
- in certain circumstances, MassHealth may not honor my request to share information.

Signature of applicant/member:

Date: ____/____/____

(See other side.)