MASSHEALTH
Permission to Share Information (PSI) Form

Use this form if you want to give MassHealth permission to

- talk with another person or organization about your eligibility,
- share copies of your eligibility notices with them, or
- share copies of your records with another person or organization.

Complete all questions under Section 2 if you want to give MassHealth permission to talk with another person or organization about your eligibility and to share copies of your eligibility notices with them. (Do not complete Section 3 unless you are asking MassHealth to share written copies of your records.) This person or organization could be someone like:

- a family member, friend, or other trusted person,
- 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.

Complete all questions under Section 3 if you want to give MassHealth permission to share copies of your records with another person or organization. (Complete Section 3 only if you are asking MassHealth to share written copies of your records.) The information included in your records may include:

- MassHealth claims showing services you have received
- Past MassHealth applications and related information you've sent to us
- Past MassHealth notices that have been sent to you

Do not use this form if you want

- information about yourself,
- copies of your own records,
- information about your children under age 18 (You can usually get this without filling out any forms.),
- 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.), or
- to create an appeal representative status related to a Fair Hearing. (You should fill out the appropriate sections on the Fair Hearings Request (FHR-1) form OR complete a current Authorized Representative Designation (ARD) form. Current versions of both forms are available at www.mass.gov/service-details/masshealth-member-forms.)

Important: If you decide you want to fill out this form, you must fill out all applicable sections. Please print clearly and remember to **sign and date Section 7.** If a legal representative is completing this form, they must **sign and date Section 8.**

SECTION 1 Name of MassHealth applicant or member

I give permission for MassHealth and its representatives to share the information listed in Section 2 or Section 3 about:

Name of applicant or member whose information is to be shared*

Street*	City*	State* MA	Zip*
Date of birth*	Telephone number		

MassHealth ID number* _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ OR Last four digits of applicant's or member's SSN* _ _ _ _

Please Note: Fields with an asterisk * are required. If you do not have a MassHealth ID number, give us the last four digits of your social security number (SSN), if you have one. If you are applying for or getting only MassHealth Limited, Children's Medical Security Plan (CMSP), or Healthy Start benefits, then we won't need your SSN.

SECTION 2 Permission for MassHealth to talk about your eligibility details and share copies of your eligibility notices

The person or organization that you write in Section 4 will be able to contact MassHealth to receive information described by the checked box below.

☐ I give MassHealth permission to do the following:

- talk about my eligibility details,
- talk about my MassHealth benefits, and
- share copies of eligibility notices with the person or organization written in **Section 4.**

Please note. These notices may contain financial information. Check this box only if you want the person or organization in Section 4 to be able to contact MassHealth to get eligibility information and get copies of your eligibility notices.

If you check this box, MassHealth will send copies of your eligibility notices to the person or organization in Section 4. They can also ask for copies of your eligibility notices. These notices have information about all members of a household. If you check this box, each member of your household who is 18 years or older will have to complete and sign a separate PSI form.

Do you also give MassHealth permission to share details about drug and alcohol treatment?

☐ Yes. MassHealth may share drug and alcohol treatment information.

☐ No. MassHealth may not share drug and alcohol treatment information.

Please Note. If you have given MassHealth permission to share your drug and alcohol treatment information for purposes of payment or health care operations activities, the recipient is permitted to further disclose your drug or alcohol treatment information to its contractors, subcontractors, or legal representatives to carry out payment or health care operations on its behalf.

SECTION 3 Permission for MassHealth to share written copies of your records

The person or organization written in Section 4 will receive copies of the records described by the checked box below.

☐ MassHealth claims showing services you have received from (month/year) _____ to (month/year) _____

☐ Past MassHealth applications and related information from (month/year) _____ to (month/year) _____

☐ Past MassHealth notices sent to you from (month/year) _____ to (month/year) _____

☐ Other (please be specific)

_____

Do you also give MassHealth permission to share drug and alcohol treatment information?

☐ Yes. MassHealth may share copies of drug and alcohol treatment information.

☐ No. MassHealth may not share copies of drug and alcohol treatment information.

Please Note: If you have given MassHealth permission to share your drug and alcohol treatment information for purposes of payment or health care operations activities, the recipient is permitted to further disclose your drug or alcohol treatment information to its contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on its behalf.

SECTION 4 Whom do you want us to share information with?

Write 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. Fields with an asterisk * are required.

MassHealth may share the information listed in Section 2 or Section 3 with

Name of person or organization*

In care of (name of person in organization to whom mail should be sent)

Street*	City*	State*	Zip*
Telephone number	Email		

SECTION 5 Why do you want us to share your information?

Tell us why you want to share the information listed in Section 2 or Section 3. If you leave this section blank, we will assume you mean "at my request."

SECTION 6 End of permission

This PSI will end in 12 months unless you write a different date here. Date (mm/dd/yyyy): ____. ____. _____

SECTION 7 Your signature

I understand the following.

- When the person or organization named in Section 4 gets this information from MassHealth, they may be able to share it with others without my permission. If they share that information, federal and state privacy laws may not protect the information.
- I need to send this PSI to the appropriate address in Section 9.
- I may cancel this permission at any time by sending a letter to:
  Health Insurance Processing Center
  PO Box 4405
  Taunton, MA 02780

- 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 4, my MassHealth benefits will not be affected in any way.
- In certain circumstances, MassHealth may not be able to share information.

Name of applicant or member (please print)

Signature of applicant or member*

Date* (mm/dd/yyyy): ____. ____. _____

Fields with an asterisk * are required.

SECTION 8 Signature of Legal Representative

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 or member (such as the parent of a minor child, an authorized eligibility representative, or a legal guardian).

Printed name of person filling out this form _____

Signature of person filling out this form _____ Date (mm/dd/yyyy): ____. ____. _____

Address

Telephone number

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

* If this form is being completed by someone who has legal authority to act on behalf of the applicant or member, such as a legal guardian appointed by a court or power of attorney, a copy of the applicable legal document must be attached.

SECTION 9 How do I submit this form?

Mail your form to:

Health Insurance Processing Center
PO Box 4405
Taunton, MA 02780

Fax your form to: (857) 323-8300

If you have only checked off boxes in Section 3 to give MassHealth permission to share copies of your claims, application file, notices, or other records, then:

Email the PSI to privacy.officer@mass.gov

or

Mail it to
MassHealth Privacy Office
One Ashburton Place, Room 1109
Boston, MA 02108