Commonwealth of Massachusetts
Department of Developmental Services

DDS Limited Release for Vision Services

SECTION I. Personal Information:

Individual's Name: _____ Other Name(s): _____

Address: _____ Phone: _____

_____

_____

Date of Birth: _____

☑ I hereby authorize the Massachusetts Department of Developmental Services (DDS) to disclose the following information about the individual named above to the Holyoke Health Center Vision Center: DDS Eligibility, Massachusetts Commission for the Blind (MCB) Eligibility, American Printing House for the Blind (APH) Federal Quota Account Eligibility, and status of Orientation & Mobility (O&M) Services through the MCB/DDS Partnership Project. This information is helpful for the eye care provider to receive prior to the exam date.

SECTION II. **Authorized Recipient(s).** I give my permission to the provider, agency, entity, or individual listed below to share/receive the information listed in Section I with/from the Department of Developmental Services:

Holyoke Health Center Vision Center - Disability Eye Care

267 High Street
Holyoke, MA 01040

SECTION III. **Purpose of Disclosure**. Please state the purpose of the use or disclosure of information (e.g. medical care, legal, insurance, personal, etc. – be specific. If you do not want to list a reason, you may simply write: "at my request," if you are initiating the request)

Obtaining vision and eye care related services.

Any other use or disclosure of this information is prohibited under Massachusetts statutes and Departmental regulations and policies.

SECTION IV. Certification. I have been informed of the benefits and disadvantages of releasing the above information and I voluntarily execute release. I understand that I have a right to revoke the authorization at any time. If I revoke this authorization, I must do so in writing and present it to the person/ facility/agency that was authorized to release the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire _____ (date or event – must not exceed one year). I understand that once the above information is disclosed, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I understand that I do not need to sign this form to continue to receive health services from DDS.

_____ _____

Signature of Individual who is the Subject of the Information or Guardian Date

_____

Print Name (and identify legal authority if signed by Guardian or other Legally/Authorized Representative)

INSTRUCTIONS:

1. This form must be completed in full (excluding Specially Authorized Releases) to be considered valid.
2. Ensure that the expiration date or event listed on page 2 is practical.
3. **Distribution of copies: Original to provider; copy to individual or personal representative; copy to person/facility/agency making request.**