Commonwealth of Massachusetts
Department of Developmental Services

AUTHORIZATION FOR RELEASE OF INFORMATION FORM

SECTION I. Personal Information:

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

Address: _____ Phone: _____

_____

_____

Date of Birth: _____

☑ I hereby authorize the Department of Developmental Services to disclose to the provider, agency, entity, or individual named in Section II below the following information:

☐ I hereby authorize the provider, agency, entity, or individual named in Section II below to release the following information to the Department of Developmental Services:

☐ Psychological Testing	☐ Complete Record	☐ Other Service Plan
☐ Medical History	☐ Medication History	☐ Guardianship Documents
☐ Educational History	☐ ITP/ISP	☐ Hospital Reports

☐ Other (Specify) _____

_____

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:

NECO Center for Eye Care Southeastern Massachusetts

Name

450 Pleasant Street

Address

East Bridgewater, MA 02333

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. Additional Disclosure(s). The Department of Developmental Services or the provider, agency, entity or individual listed in Section II may share my information with this person(s) or organization:

_____
Name

_____
Organization

_____
Address

SECTION V. 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)

SECTION VI. Specific Authorizations. I specially authorize release of the following information (please check all that apply):

☐ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by M.G.L. c.111 S.70F, an HIV/AIDS diagnosis or HIV/AIDS treatment, I specifically authorize release or disclosure of such information.

☐ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation, 42 CFR, Part 2, I specifically authorize release or disclosure of such information.

_____ _____
Signature of individual who is the subject of the Information or Guardian Date

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.**