MASSHEALTH/CASUALTY RECOVERY UNIT
PERMISSION TO SHARE INFORMATION (PSI) FORM

When to use this form:

- **Use this form** if you want the Casualty Recovery Unit to share the information we have about you with another person or organization, such as:
  - a family member, friend, or other relative;
  - an attorney representing you,
  - a social worker, lawyer, or health-care advocacy group;
  - an insurance company settling a case on your behalf.

Where to send this form:

- If you are authorizing the sharing of **only medical claims information** send the PSI to:

Commonwealth of Massachusetts
Casualty Recovery Unit
P. O. Box 15205
Worcester, MA 01615-0205

OR

Fax: 1-508-856-7672

Section 1 Name of MassHealth member:

Permission is given for the Casualty Recovery Unit and its representatives to share information listed in **Section 2** about:

(Name of member whose information is to be shared)

Street

City/State/Zip

Date of Birth Telephone number

MassHealth ID number

Please note: If you do not have a MassHealth ID number, please use your social security number.

Section 2 What information do you want shared? Please be aware that the information you are requesting us to share on your behalf may include financial information.

Check the box or boxes that apply.

☐ I am giving the Casualty Recovery Unit permission to share MassHealth Claims information pertaining to my accident which includes MassHealth claims from: _____ to _____
(month/year) (month/ year)

☐ other (please be specific)

By giving the Casualty Recovery Unit this permission to share information, are you also giving the Casualty Recovery Unit permission to share drug and alcohol treatment information?

☐ 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.

Casualty Recovery Unit may share the information listed in **Section 2** with

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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

Fax Number

Casualty Recovery Unit relies on the contact information you provide. Please be certain this contact information is correct.

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 leave this section blank, we will assume "at my request."

Section 5 End of Permission

This PSI will end in 18 months unless you specify an end date here. _____

Section 6 Your Signature

I understand the following:

- When the person or organization named in **Section 3** gets this information from the Casualty Recovery Unit, 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 to the address on the front page.
- I may cancel this permission at any time by sending a letter to:
  Casualty Recovery Unit, **P.O. Box 15205, Worcester, MA 01615-0205**
- Even if I cancel this permission, the Casualty Recovery Unit cannot take back any information that it shared when it had my permission to do so.
- If I do not give the Casualty Recovery Unit Permission to share information, or if I cancel my permission to share information with the person or organization named in **Section 3**, my MassHealth benefits will not be affected in any way.

_____
Name of Member (Print)

_____
Signature of Member Date

Section 7 Signature/Legal Guardian

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 eligibility representative, or a legal guardian).

_____
Printed 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 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.*