University of Massachusetts
UMASS. Medical School

DISABILITY EVALUATION SERVICES (DES)
333 South Street, Shrewsbury, MA 01545

Authorization to Release Information

1. I authorize Disability Evaluation Services (DES) to use or disclose the information contained in the DES records of the Individual listed below. I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Please complete all sections of this form.

Name: ______________________________ Date of Birth: ______________
Address: ____
(street) (city) (state) (Zip)
Last 4 digits of SSN: ____ ____ ____ ____ Phone number: ______________

2. DES is authorized to release the following information:
- ❑ Most recent DES Medical Consultative Exam
- ❑ Records from Most Recently Closed file
- ❑ Most recent DES Psychological Consultative Exam
- ❑ Other ______________
- ❑ Records dated ________ to ________

3. DES is authorized to release the information to:
Name: ____
Address: ____
(street) (city) (state) (Zip)

4. I understand that the records may include mental health; HIV/AIDS; alcohol / drug abuse; and genetic records. If you do not want these records released, please check the appropriate boxes below.

I do NOT allow the release of records that contain:
❑ Mental Health records ❑ HIV/AIDS records; ❑ Alcohol/drug abuse treatment records; ❑ Genetic records

5. I authorize the release of this information for the following purpose: ______________

6. This authorization expires 6 months from signature date.

I understand that I have the right to revoke this authorization in writing at any time, unless it has already been acted upon. To revoke this authorization, I need to send my request in writing to Disability Evaluation Services, 333 South Street, Shrewsbury, MA 01545 and include name, address, and phone number in the request.

I understand that if I choose not to give or if I choose to cancel this permission I will still be eligible for benefits if I am entitled to them.

______________________ ______________________ ______________
Printed Name of Individual | Signature of Individual | Date (MM/DD/YEAR)

If the Individual is a child or is incapacitated, the parent/guardian or person who is authorized by law to sign for the Individual must sign below and provide the legal document granting such authority.***

______________________ ______________________ ______________
Signature of Individual's Personal Representative | Relationship to Individual | Date (MM/DD/YEAR)

***If this form is being filled out by someone who has been appointed by 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.