

**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**



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

Name of Person or Organization

Lien Resolution Group

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

Street

55 Old Nyack Turnpike Rd., Ste 311 Nanuet, NY 10954

City/State/Zip

845-638-1278

Telephone number

845-638-1237

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.*