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: ________________________________

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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.
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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.

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

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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.**