

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

Name: Other Name(s):

Address: Phone:

Social Security #: Date of Birth:

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: Attention: Phone:

Street: City/Town: State: Zip:

DMH Contact Information:

Name: Phone:

Address:

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request.

Specify information to be released:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Evaluations | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Admission Documentation | <input type="checkbox"/> Transfer Summary | <input type="checkbox"/> Assessments & Tests | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> ISPs & IAPs | <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Consultations <i>(include name of consultant)</i> |
| <input type="checkbox"/> Psychiatry Notes | <input type="checkbox"/> Neuropsych Testing | <input type="checkbox"/> Other <i>(specify below)</i> | |

Purpose for the authorization (must check one):

The subject of the information or Personal Representative initiated the authorization (specific purpose not required)

Or

Coordinate care Facilitate billing

Referral Obtain insurance, financial or other benefits

Other purpose (please specify): _____

A copy of this authorization shall be considered as valid as the original.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Authorization for Release of Information
Two-Way (continued)

Name of person/facility/agency other than DMH to receive or release information: _____

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to DMH at DMH address identified on page one. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire (specify a date, time period or an event) _____ or, if nothing is specified, it will expire when I am no longer receiving services from DMH. I understand that once the above information is disclosed to a person, facility or agency outside DMH, 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 need not sign this form to receive treatment or services from DMH and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent DMH, and/or the other named person, facility or agency, from providing appropriate and necessary care.

X _____ Date _____
Your signature or Personal Representative's signature

Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent) _____

Specially Authorized Releases of Information (please initial all that apply)

____ 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 of such information.

____ To the extent that my medical record contains **information concerning HIV antibody and antigen testing** that is protected by MGL c.111 §70F, an HIV/AIDS diagnosis or treatment; I specifically authorize disclosure of such information.

X _____ Date _____
Your signature or Personal Representative's signature

INSTRUCTIONS:

1. This form must be completed in full to be considered valid.
 2. Distribution of copies: original to appropriate DMH record; copy to Individual or Personal Representative; copy to person/facility/agency making request.
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Or

- | | |
|--|--|
| <input type="checkbox"/> Coordinate care | <input type="checkbox"/> Facilitate billing |
| <input type="checkbox"/> Referral | <input type="checkbox"/> Obtain insurance, financial or other benefits |
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Commonwealth of Massachusetts
Department of Mental Health

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

*Protected Health Information (PHI)

PLEASE REVIEW IT CAREFULLY

Notice Effective Date: December 15, 2010
Version 6

Privacy

The Department of Mental Health (DMH) is required by state and federal law to maintain the privacy of your protected health information (PHI). PHI includes any identifiable information about your physical or mental health, the health care you receive, and the payment for your health care.

DMH is required by law to provide you with this notice to tell you how it may use and disclose your PHI and to inform you of your privacy rights. DMH must follow the privacy practices as set forth in its most current Notice of Privacy Practices.

This notice refers only to the use/disclosure of PHI. It does not change existing law, regulations and policies regarding informed consent for treatment.

Changes to this Notice

DMH may change its privacy practices and the terms of this notice at any time. Changes will apply to PHI that DMH already has as well as PHI that DMH receives in the future. The most current privacy notice will be posted in DMH facilities and programs, and on the DMH website (www.mass.gov/dmh), and will be available on request. Every privacy notice will be dated.

How Does DMH Use and Disclose PHI?

DMH may use/disclose your PHI for treatment, payment and health care operations without your authorization. Otherwise, your written authorization is needed unless an exception listed in this notice applies.

Uses/Disclosures Relating to Treatment, Payment and Health Care Operations

The following examples describe some, but not all, of the uses/disclosures that are made for treatment, payment and health care operations.

For treatment - Consistent with its regulations and policies, DMH may use/disclose PHI to doctors, nurses, service providers and other personnel (e.g., interpreters), who are involved in delivering your health care and related services. Your PHI will be used to help make a determination on your application for DMH services, to assist in developing your treatment and/or service plan and to conduct periodic reviews and assessments. PHI may be shared with other health care professionals and providers to obtain prescriptions, lab work, consultations and other items needed for your care. PHI will be shared with DMH service providers for the purposes of referring you for DMH services and then for coordinating and providing the DMH services you receive.

To obtain payment - Consistent with the restrictions set forth in its regulations and policies, DMH may use/disclose your PHI to bill and collect payment for your health care services. DMH may release portions of your PHI to the Medicaid or Medicare program or a third party payor to determine if they will make payment, to get prior approval and to support any claim or bill.

For health care operations - DMH may use/disclose PHI to support activities such as program planning, management and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare), audits, training and credentialing of health care professionals, and certification and accreditation (e.g., The Joint Commission).

Appointment Reminders

DMH may use PHI to remind you of an appointment or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses/Disclosures Requiring Authorization

DMH is required to have a written authorization from you or your personal representative with the legal authority to make health care decisions on your behalf for uses/disclosures beyond treatment, payment and health care operations unless an exception listed below applies. You may cancel an authorization at any time, if you do so in writing. A cancellation will stop future uses/disclosures except to the extent DMH has already acted based upon your authorization.

Exceptions

- For guardianship or commitment proceedings when DMH is a party
- For judicial proceedings if certain criteria are met
- For protection of victims of abuse or neglect
- For research purposes, following strict internal review
- If you agree, verbally or otherwise, DMH may disclose a limited amount of PHI for the following purposes:
 - **Clergy** – Your religious affiliation may be shared with clergy
 - **To Family and Friends** – DMH may share information directly related to their involvement in your care, or payment for your care
- To correctional institutions, if you are an inmate

- For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities
- If required by law, or for law enforcement or national security
- To EOHHS and/or its agencies, such as MassHealth, DCF, DDS, DYS, DTA and DPH for functions including service delivery, eligibility and program management.
- To avoid a serious and imminent threat to public health or safety
- For public health activities such as tracking diseases and reporting vital statistics
- Upon death, to funeral directors and certain organ procurement organizations

Your Rights

You, or a personal representative with legal authority to make health care decisions on your behalf, have the right to:

- Request that DMH use a specific address or telephone number to contact you. DMH is not required to comply with your request.
- Obtain, upon request, a paper copy of this notice or any revision of this notice, even if you agreed to receive it electronically.
- *Inspect and copy PHI that may be used to make decisions about your care. Access to your records may be restricted in limited circumstances. If you are denied access, in certain circumstances, you may request that the denial be reviewed. Fees may be charged for copying and mailing.
- *Request additions or corrections to your PHI. DMH is not required to comply with a request. If it does not comply with your request, you have certain rights.
- *Receive a list of individuals who received your PHI from DMH (excluding disclosures that you authorized or approved, disclosures made for treatment, payment and healthcare operations and some required disclosures).
- *Ask that DMH restrict how it uses or discloses your PHI. DMH is not required to agree to a restriction.

*** These requests must be made in writing**

Record Retention

Your individual records relating to DMH provided care and services will be retained at a minimum for 20 years from the date you are discharged from inpatient care and/or from the applicable community services. After that time, your records may be destroyed.

To Contact DMH or to File a Complaint

If you want to obtain further information about DMH's privacy practices, or if you want to exercise your rights, or you feel your privacy rights have been violated, or you want to file a complaint, you may contact: DMH Privacy Officer, Department of Mental Health, 25 Staniford Street, Boston, MA 02114, Phone: 617-626-8160, Fax: 617-626-8131, E-mail: PrivacyOfficer@dmh.state.ma.us. A complaint must be made in writing.

You also may contact a DMH facility's medical records office (for that facility's records), a DMH program director (for that program's records), your site office (for case management records), or the human rights officer at your facility or program, for more information or assistance.

No one may retaliate against you for filing a complaint or for exercising your rights as described in this notice.

You also may file a complaint with the **Secretary of Health and Human Services**, Office for Civil Rights, U.S. Department of Health and Human Services, JFK Federal Building, Room 1875, Boston, MA. 02203.