

Commonwealth of Massachusetts
 Department of Mental Health
Recovery from Addiction Program
Authorization for Release of
Records for Legal Proceedings

1. Patient/Applicant Information	
Name: _____	Other Names: _____
Street: _____	APT.#: _____
City/Town: _____	State: _____ Zip Code: _____
Last 4 digits of SSN: _____	Date of Birth: _____
Phone : _____	

<p>2. Authorization to Release: I authorize the Department of Mental Health Recovery from Addictions Program (RAP) to use and disclose my substance use disorder treatment records (or testimony relating information contained in my record) to be used in the criminal, civil, legislative, or administrative proceeding identified below.</p> <p>Case No./Investigation No. (if known): _____</p> <p>_____</p>
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<p>Records are authorized to be released to:</p> <p>Name: _____</p> <p>Attention: _____</p> <p>Street: _____</p> <p>City/Town: _____</p> <p>State/Zip Code: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>	<p>RAP Contact Information:</p> <p>Name: _____</p> <p>Street: _____</p> <p>City/Town: _____</p> <p>State/Zip Code: _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email: _____</p>
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3. Check to indicate the information you want shared: (check all that apply)		
<input type="checkbox"/> Entire Treatment Record, <i>excluding Substance Use Disorder Counseling Notes, which require a separate authorization</i>		
<input type="checkbox"/> Discharge Summary / Aftercare Plan / Medication List	<input type="checkbox"/> Physical Exam	<input type="checkbox"/> Health insurance Information
<input type="checkbox"/> Admission Assessments	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Copy of ID (Lic / Intake Photo)
<input type="checkbox"/> Admission Psych Assessment	<input type="checkbox"/> Medication List	<input type="checkbox"/> Presence in Treatment Letter
<input type="checkbox"/> Biopsychosocial Evaluation	<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Lab / X-Ray Reports
<input type="checkbox"/> HIV Testing / results / treatment (See requirement of Section 5 below.)		

Other (please specify) / additional information: _____

4. Dates of the records you want shared: (Specify dates)
Dates of Requested Information: From: _____ To: _____

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Patient/Applicant Name: _____

5. Please *initial* to indicate you give permission to release the following information if present in your record: (*initial* all that apply)

Initial Here: _____ HIV test results (Authorization required for each release request.)

Initial Here: _____ Substance Use Disorder Records Protected by Federal Confidentiality Regulations 42 CFR Part 2.

Purpose of the Release: Legal

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 the RAP at the address where I received treatment by the RAP. The revocation will not apply to information that has already been released pursuant to this authorization.
- Once the above information is released, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations, including 42 CFR Part 2.
- Authorizing the disclosure of the information identified above is voluntary.
- I need not sign this form to receive treatment or services from RAP.

This authorization will expire (specify a date, time period or an event) _____ or, if nothing is specified, it will expire one year from date of signing.

Please check that you have specifically authorized the release of Substance Use Disorder Records by initialing Section 5 above, where indicated.

6. Signature / Authorization: Sign and provide information as required below.

X _____
Your signature or Legally Authorized Representative's signature Date

Print name of signer

The following information is needed if signed by a legally authorized representative:

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

Distribution of copies: Original retained by the RAP, copy to the individual or their legally authorized representative.