Commonwealth of Massachusetts
Department of Mental Health
Recovery from Addiction Program
Authorization for Release of
Substance Use Disorder Counseling Notes

1. Patient/Applicant Information

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

2. Authorization to Release: I authorize the Department of Mental Health Recovery from Addictions Program (RAP) to receive and release **Substance Use Disorder Counseling Notes**, from or to the Person, Agency or Facility named below, either verbally or in writing.

Person, Agency or Facility (e.g., name and address of hospital, outpatient provider, residential program, other)	RAP Contact Information:
Name: _____	Name: _____
Attention: _____	Street:_____
Street:_____	City/Town: _____
City/Town: _____	State/Zip Code: _____
State/Zip Code: _____	Phone: _____
Phone: _____	Fax: _____
Fax: _____	Email: _____

3. Dates of the substance use disorder counseling notes you want shared: (Specify dates)

Dates of Requested Information: From: _____ To: _____

4. Purpose of the Release: (must check one)

☐ Treatment, Payment, and Health Care Operations
☐ Treatment ☐ Referral ☐ Facilitate billing ☐ Coordinate care
☐ Obtain insurance, financial or other benefits ☐ Legal ☐ Personal Use
☐ Other purpose (please specify): _____

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.

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Patient/Applicant Name: _____

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 and/or the other named person, facility or agency; however, lack of ability to share or obtain information may prevent RAP, and/or the other named person, facility or agency, from providing appropriate and necessary care.

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.

5. 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.