COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
One-Way To Department of Mental Health

Name: Other Name(s):

Address: Phone:

Social Security #: Date of Birth:

I authorize the following person, facility or agency:

Name: Attention: Phone:

Street: City/Town: State: Zip:

to release information, either verbally or in writing to the Department of Mental Health (DMH).

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 e.g. Entire Record, Admission(s) Documentation, Discharge Summary(ies), Transfer Summary(ies), Evaluations, Assessments and Tests, Consultation(s) including names of consultant(s), Treatment Plan(s), ISP(s) & PSTP(s), Physical Exam & Lab Reports, Progress Note(s):

_____
_____
_____
_____
_____
_____
_____
_____

Purpose for the authorization:

☐ 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 (continued)
One-Way To Department of Mental Health

Name of person/facility/agency to release information to DMH:_____

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 person, facility or agency authorized to release information to DMH. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. This authorization will expire in 12 months unless otherwise specified (specify a date, time period or an event):_____. I understand that once the above information is disclosed it may be redisclosed and no longer 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 person, facility or agency authorized to release information to DMH. However, lack of ability to share or obtain information may prevent DMH, and/or other person, facility or agency, from providing appropriate and necessary care.

_____ _____
Your signature or Personal Representative's signature Date

_____
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, or an HIV/AIDS diagnosis or treatment, I specifically authorize disclosure of such information.

_____ _____
Your signature or Personal Representative's signature Date

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.