Commonwealth of Massachusetts
Department of Mental Health
Authorization for Release of
Psychotherapy 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 (DMH) to receive and release **Psychotherapy 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)	DMH 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 psychotherapy notes you want shared: (Specify dates)

Dates of Requested Information: From: _____To: _____

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

☐ Treatment ☐ Coordinate care ☐ Payment ☐ Personal Use
☐ Obtain insurance, financial or other benefits
☐ 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 DMH at the DMH address identified above or the DMH office in my area. (Find DMH area offices at www.mass.gov/dmh-offices-facilities-and-staff-directory; call 1-800-221-0053; or email dmhinfo@MassMail.State.MA.US.)
- 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.
- Authorizing the 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.

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.

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

X _____ _____
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): _____

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