Commonwealth of Massachusetts Department of Mental Health Authorization for Release of Psychotherapy Notes Two Way

1. Patient/Applicant Information		
Name: C	Other Names:	
Street:	APT.#:	
City/Town: State	te:	Zip Code:
Social Security #:	Date of Birth:	
Phone :		
2. Authorization to Release: I authorize the D release Psychotherapy Notes, from or to the Perverbally or in writing. Person, Agency or Facility (e.g., name and address of hospital, outpatient provider, residential program, other) Name: Attention: Street: City/Town: State/Zip Code: Phone: Fax:	rson, Agency or F DMH Contact I Name: Street: City/Town: State/Zip Code Phone: Fax:	acility named below, either
3. Dates of the psychotherapy notes you want shared: (Specify dates)		
Dates of Requested Information: From: To:		
4 Dumage of the Delegacy (must shock one)		
4. Purpose of the Release: (must check one) ☐ Personal Use ☐ Coordinate care ☐ Referral ☐ Facilitate billing		
Obtain insurance, financial or other benefits		
Other purpose (please specify):		
Cities parpose (pieces specify).		

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.
- 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.

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Patient/Applicant Name:		
 I understand that: 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):		