Commonwealth of Massachusetts
Department of Mental Health (DMH)
Release of Information for Social Supports

1. Patient/Applicant Information

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

Authorization to and Purpose of Release: I authorize DMH to receive and release my individually identifying and protected health information for purposes of determinations of eligibility and maintenance of social supports, such as, health benefits, housing, financial assistance, other public benefits, and job readiness (vocational rehabilitation, educational, training and/or employment related services) offered by federal, state, and municipal agencies, collectively referred to as "social support agencies", either verbally or in writing. I authorize all such social support agencies to receive and release my individually identifying and all other confidential information to DMH for these purposes, either verbally or in writing.

This release does not include authorization to release the Patient/Applicant's HIV test results or substance use disorder information or records protected by Federal Confidentiality Rules 42 CFR Part 2.

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 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.
- 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; however, lack of ability to share or obtain information may prevent DMH from providing appropriate and necessary care.

This authorization will expire the later of: (i) five (5) years from date of signing; or (ii) if applicable, one (1) year after I am no longer receiving services from DMH.

2. 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): _____

If court appointed provide copy of court order.

Distribution of copies: Original retained by DMH; copy to the individual or personal representative.