Authorization for Release of Information
Two Way

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 information, including confidential communications, 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 Service Authorization Unit ***For DMH Use Only***
Name:		
Attention:		
Street:		
City/Town		
State/Zip Code:		
Phone:		
Fax:		

3. Check to indicate the information you want shared: (*check* all that apply)

☐ Mental Health Diagnosis and Treatment provided by a Psychiatrist; Psychologist; Mental Health Clinical Nurse Specialist; Licensed Social Worker Counseling; all other Licensed Mental Health Providers.		
☐ Entire Mental Health Record, *excluding Psychotherapy Notes which require a separate authorization*		
☐ Discharge Summary		☐ Treatment Plans
☐ ISPs & IAPs	☐ Neuropsych Testing	☐ Transfer Summary
☐ Admission Documentation	☐ Physical Exam	☐ Lab Reports
☐ Other (please specify) / additional information:		

4. Dates of the information you want shared: (Specify dates OR select 3 year period by checking the box)

Dates of Requested Information: From: To:

OR ☐ For the 3 year period prior to the date of this authorization.

Authorization for Release of Information
Two Way

Patient/Applicant Name:

5. Please *initial* to indicate that you give permission to release the following information if present in your record: (*initial* all that apply)	
☐	HIV test results (Authorization required for each release request.)
☐	Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Purpose of the Release: Service authorization.

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 on page one 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.
- 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 the later of (i) one year from date of signing; or (ii) if applicable, when I am no longer receiving services from DMH.

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

X _____ _____

Your **hand-signature**, or that of a Personal Representative's is **Required** 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.