

Commonwealth of Massachusetts
 Department of Mental Health
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) Name: _____ Attention: _____ Street: _____ City/Town: _____ State/Zip Code: _____ Phone: _____ Fax: _____	DMH Contact Information: Name: _____ Street: _____ City/Town: _____ State/Zip Code: _____ Phone: _____ Fax: _____ Email: _____

3. Check to indicate the information you want shared: (check all that apply)		
<input type="checkbox"/> 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.		
<input type="checkbox"/> Entire Mental Health Record, <i>excluding Psychotherapy Notes which require a separate authorization</i>		
<input type="checkbox"/> Entire Record (Medical and Mental Health)	<input type="checkbox"/> ISPs & IAPs	<input type="checkbox"/> Treatment Plans
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Neuropsych Testing	<input type="checkbox"/> Transfer Summary
<input type="checkbox"/> Admission Documentation	<input type="checkbox"/> Physical Exam	<input type="checkbox"/> Lab Reports

Other (please specify) / additional information:

4. Dates of the information you want shared: (Specify dates)	
Dates of Requested Information: From: _____	To: _____

Commonwealth of Massachusetts
Department of Mental Health
Authorization for Release of Information
Two Way

Patient/Applicant Name: _____

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: _____ 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.

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

Personal Use Coordinate care Referral Facilitate billing

Obtain insurance, financial or other benefits

Other purpose (please 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 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 one year from date of signing.

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

X _____ Date _____
Your signature or Personal Representative's signature

Print name of signer

The following information is needed if signed by a personal representative:

Type of authority (e.g., court appointed, custodial parent): _____