Commonwealth of Massachusetts

Department of Mental Health

Authorization for Release of Psychotherapy Notes

Two Way

1. Patient/Applicant Information

Name: ______________________________

Other Names: ______________________________

Street: ______________________________ APT.#: ____________

City/Town: ______________________ State: __________ Zip Code: _________

Social Security #:__________________ 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)

☐ Personal Use ☐ Coordinate care ☐ Referral ☐ Facilitate billing

☐ Obtain insurance, financial or other benefits

☐ Other purpose (please specify below):

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): _____________________________