COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Audit Trail Request Form

Name: Other Name(s):

Address: Phone:

Social Security#: Date of Birth:

DMH facility/office/program to which you are submitting this request: _____

_____

You may request a list of certain disclosures of your Protected Health Information (PHI) made by the Department of Mental Health (DMH). Please consider the following in making a request:

- The list is free once in any 12-month period. DMH may charge you for any additional requests in the same 12-month period.
- The list will be provided to you within 60 days unless DMH notifies you in writing that a 30-day extension is needed.
- DMH is not required to list disclosures made more than six years before your request.
- DMH is not required to list disclosures made earlier than April 14, 2003.
- DMH is not required to list disclosures that you authorized.
- DMH is not required to list disclosures to you or your Personal Representative.
- DMH is not required to list disclosures made to carry out treatment, payment or healthcare operations.
- DMH is not required to list certain disclosures made to persons involved in your care with your consent.
- DMH is not required to list disclosures made for certain governmental purposes.

(1) I am asking for a list of disclosures of my PHI for the following period of time [be specific]:
From: _____ To: _____

(2) Name(s) of the DMH facilities, Area and Site offices and programs with which you had contact during the period of time you specified above: _____
_____
_____
(Complete to the extent possible. Your request will be processed even if this section is left blank)

(3) Check One:
____ I would like to pick up the list when it is ready.
____ Please mail the list to the address given above.
____ Please mail the list to this address _____

_____ _____
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): _____

For DMH Use

Date request received: _____ DMH location where request received: _____

Received by: _____ _____
signature printed name