COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Confidential Communication Request Form

Name: Other Names:

Address: Phone:

Social Security#: Date of Birth:

You or your Personal Representative (PR) have the right to request that you receive communications from the Department of Mental Health (DMH) at an alternative location or by alternative means.

- If you or your PR want an alternative location or means of communication to be used by DMH, you must specify such alternative location or means of communication in this request.
- You will be notified of DMH's response to your request in writing.
- Even if DMH agrees to your request, there may be times when DMH needs to contact you at any known address and/or by any available means.
- Even if DMH agrees to your request, this decision may be revoked by DMH if the alternative location or means of communication become unreasonable. Written notice of the revocation will be provided to you or your PR. The revocation will be effective only after such notice is given.

I am asking DMH to communicate with me in the following manner (specify location or manner of communication):

_____
_____
_____
_____
_____
_____

_____ _____
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

Approved: ☐ Denied: ☐

Signature: _____ Title: _____ Date: _____