

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Restriction Of Use & Disclosures Request Form

Name:

Other Name(s):

Address:

Phone:

Social Security #:

Date of Birth:

You have the right to request restriction of the use and/or disclosure of your Protected Health Information (PHI) by the Department of Mental Health (DMH). If you are asking to limit use or disclosure of such information, please consider the following:

- § DMH will consider your request, but DMH does not have to agree to your request. You will be notified in writing of DMH's decision to accept or deny your restriction request. If DMH agrees to a restriction, DMH may terminate the agreement at any time by giving you written notice.
 - § Where your authorization is required for the use or disclosure of your Protected Health Information, any restrictions on such use or disclosure will be addressed in the authorization process.
 - § Protected Health Information that is needed for emergency treatment will be shared regardless of any restriction.
 - § Protected Health Information that is required by law to be disclosed will be disclosed regardless of any restriction.
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I am asking DMH to limit the use or disclosure of my Protected Health Information as follows (be specific):

I am making this request for the following reason(s):

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: ☐ State reason(s):

Signature: Title: Date:
