

Commonwealth of Massachusetts
 Department of Mental Health
Recovery from Addictions Program
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 Recovery from Addictions Program (DMH RAP) 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 RAP 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"/> Entire Treatment Record, <i>excluding Substance Use Disorder Counseling Notes, which require a separate authorization</i>		
<input type="checkbox"/> Discharge Summary / Aftercare Plan / Medication List	<input type="checkbox"/> Physical Exam	<input type="checkbox"/> Health insurance Information
<input type="checkbox"/> Admission Assessments	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Copy of ID (Lic / Intake Photo)
<input type="checkbox"/> Admission Psych Assessment	<input type="checkbox"/> Medication List	<input type="checkbox"/> Presence in Treatment Letter
<input type="checkbox"/> Biopsychosocial Evaluation	<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Lab / X-Ray Reports
<input type="checkbox"/> HIV Testing / results / treatment (See requirement of Section 5 below.)		
<input type="checkbox"/> Other (please specify) / additional information: _____		

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

