

Commonwealth of Massachusetts
 Department of Mental Health
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 (DMH) 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 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"/> Mental Health Diagnosis and Treatment provided by a Psychiatrist; Psychologist; Mental Health Clinical Nurse Specialist; Licensed Social Worker Counseling; all other Licensed Mental Health Providers.		
<input type="checkbox"/> Entire Mental Health Record, <i>excluding Psychotherapy Notes which require a separate authorization</i>		
<input type="checkbox"/> Entire Record (Medical and Mental Health)	<input type="checkbox"/> ISPs & IAPs	<input type="checkbox"/> Treatment Plans
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Neuropsych Testing	<input type="checkbox"/> Transfer Summary
<input type="checkbox"/> Admission Documentation	<input type="checkbox"/> Physical Exam	<input type="checkbox"/> Lab Reports

Other (please specify) / additional information:

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

