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: _____
Social Security #:_____ 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)	DMH Contact Information:
Name: _____	Name: Sara Dugas
Attention: _____	Street: 167 Lyman St. Hadley Bldg.
Street:_____	City/Town: Westborough
City/Town: _____	State/Zip Code: MA 01581
State/Zip Code: _____	Phone: 508-614-9265
Phone: _____	Fax: 508-616-2894
Fax: _____	Email: Sara.Dugas@Mass.Gov

3. Check to indicate the information you want shared: (*check* all that apply)

Mental Health Diagnosis and Treatment provided by a Psychiatrist; Psychologist; Mental

☐ Entire Mental Health Record, *excluding Psychotherapy Notes which require a separate authorization*
Entire Record (Medical and Mental Health)

☐ ISPs & IAPs		
☐ Discharge Summary	☐ Neuropsych Testing	☐ Transfer Summary
☐ Admission Documentation	☐ Physical Exam	☐ Lab Reports
☐	☐	☐

☐ Other (please specify) / additional information: _____
_____

4. Dates of the information you want shared: (Specify dates)

Dates of Requested Information: From: _____ To: _____

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Patient/Applicant Name: _____

5. Please *initial* to indicate you give permission to release the following information if present in your record: (*initial* all that apply)

Initial Here: _____ HIV test results (Authorization required for each release request.)

Initial Here: _____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

6. Purpose of the Release: (must check one)

☐ Personal Use ☐ Coordinate care ☐ Referral ☐ Facilitate billing

☐ Obtain insurance, financial or other benefits

☐ Other purpose (please specify): _____

I understand that:

I have a right to revoke this authorization at any time.

If I revoke this authorization, I must do so in writing and present it to DMH at the DMH address identified on page one or the DMH office in my area. (Find DMH area offices at www.mass.gov/dmh-offices-facilities-and-staff-directory; call 1-800-221-0053; or email dmhinfo@MassMail.State.MA.US.)

The revocation will not apply to information that has already been released pursuant to this authorization.

The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Once the above information is released, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations.

Authorizing the disclosure of the information identified above is voluntary.

I need not sign this form to receive treatment or services from DMH and/or the other named person, facility or agency; however, lack of ability to share or obtain information may prevent DMH, and/or the other named person, facility or agency, from providing appropriate and necessary care.

This authorization will expire (specify a date, time period or an event) _____or, if nothing is specified, it will expire one year from date of signing.

7. Signature / Authorization: **Sign and provide information as required below**.

X _____ _____
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): _____