

**COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH**

NOTIFICATION REGARDING ABSENCE WITHOUT AUTHORIZATION

Court _____
Name of Court

District Attorney _____
County

Next of Kin _____
Name/Address

Legally Authorized Representative (i.e. Guardian) _____
Name/Address

DMH Area _____ Date _____ Time of Notice _____

Facility _____ Address _____

Facility Contact Person _____ Telephone _____

Name of Patient _____ DOB _____ Legal Status _____

Sex: M F Home Address: _____

Pursuant to 104 CMR 27.16 (2)(d), you are hereby notified that the just named patient was absent without authorization from this facility as of _____ at _____.
date time

Steps are being taken to safely return this patient to the facility. If you have any information that would assist us in securing the patient's safe return, please contact the facility contact person listed above. You will be notified when the patient is returned or discharged from the facility.

Instructions: Individual copies of this form shall be sent to any or all of the above, as appropriate, and filed in the patient's medical record.