The HARRIS CENTER for Mental Health and IDD

To whom it may concern:

In order to help us process your request in a timely manner we would need the following information on the **Authorization to Disclose Health Information** form to be completed properly.

- Individual's name
- Date of Birth
- Social Security # or Case number
- Who you are authorizing
- Check one of the following: To disclose to **or** To receive from
- Check if you would like the information
    - Mailed to you **or**
    - Picked up (if pick up please be sure to add a phone number that you can be reached at)
- Name, Address, City, State, Zip code and phone number to whom the information is to be release to.
- Date of services (if known)
- Check all necessary information you would like disclosed.
- Check the purpose for the request.
- Type of disclose – check types of disclose
- Sign and date the Authorization
- If you are the LAR (legal authorized representative) sign and date the Authorization.

Once you have completed filling out the Authorization mail it to:

The Harris Center for Mental Health and IDD
Attn: H.I.M. Department
9401 Southwest Freeway
Houston, Texas 77074

If you have any questions or need assistance completing the Authorization, you can call (713) 970-7330. Email: ROICoordinator@TheHarrisCenter.org or Facsimile: (713) 970-3817.

Thank you,

The HARRIS CENTER for Mental Health and IDD

AUTHORIZATION TO DISCLOSE CONSUMER HEALTH INFORMATION

Individual/Patient (Print)	Date of Birth	SS# or Case Number	Medicaid #

I hereby authorize: ☐ **To disclose to** ☐ **To receive from** **Pickup** _____ **Mail** _____

The Harris Center	Name (Print):
Street Address	Address:
City, State, Zip	City/State/Zip:
Phone and/or Fax	Phone and/or Fax:

my health information as listed below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive this information is not a covered entity as defined under federal privacy regulations, the disclosed information, except chemical dependency information, may no longer be protected by federal privacy regulations.

Date (s) of Service (if known): _____

Description of information to be disclosed: (check minimum necessary for purpose)

☐ Assessments	☐ Medical History	☐ Discharge Summary	☐ Educational
☐ Psychological Evaluation	☐ Service/Treatment Plans	☐ Physicians Orders	☐ Financial/Billing
☐ Psychiatric Evaluation	☐ Medications Prescribed	☐ Laboratory Reports	☐ Alcohol/drug abuse
☐ HIV Information	☐ Diagnosis	☐ Progress Notes	☐ Vocational

☐ Other–specify: _____

Description of the purpose of the use and/or disclosure: (check only what is applicable)

☐ Follow-up/Follow-along	☐ To aid in treatment planning	☐ Continuity of care
☐ Verification of maintaining appointments	☐ Financial/Insurance verification	☐ Monitor medical status
☐ Determine eligibility-Social Security Disability, etc.	☐ Medication Verification	☐ Legal proceedings/Court Updates
☐ Residential placement	☐ Assess/monitor treatment needs	☐ At individual/patient request

☐ Other – specify: _____

Type of disclosure: ☐ Paper copy ☐ Electronic and paper copy ☐ Verbal only ☐ Verbal and paper copy ☐ Review only

I understand that this authorization will expire within one year from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____

I understand that I may revoke this authorization at any time by notifying The Harris Center in writing. I also understand that the written revocation must be signed and dated later than the date on this authorization. The revocations will not affect any actions taken before the receipt of the written revocation.

Individual/Patient or LAR Signature Date	Print name of Legally Authorized Representative (LAR)
Witness (If individual/patient is unable to sign	Representative's relationship to individual/patient
OR	
Witness (If individual/patient is unable to sign	Legal Authority (attach supporting documentation)

A PHOTOCOPY OR FACSIMILE TRANSMISSION IS AS VALID AS THE ORIGINAL FOR TREATMENT, PAYMENT, EDUCATIONAL AND/OR BENEFIT DETERMINATION PURPOSES.

_____ Signature/Date

Identity of requestor verified; ☐ Picture ID ☐ Signature ☐ Known to me

Paper disclosure processed by: _____ Staff Printed Name/Initial/Date

Authorization revoked on: _____ MM/DD/YYYY And noted by _____ Staff printed name and initials See signed revocation on reverse side.

REC: 016(Ana) (6/14) Front/Back ID Original in Chart – Yellow Copy to the Individual/Patient

The HARRIS CENTER for Mental Health and IDD

REVOCATION OF AUTHORIZATION TO DISCLOSE CONSUMER HEALTH INFORMATION

Individual/Patient Name: _____ Case #: _____

Date of Birth: _____ Social Security #: _____

As of this day, _____ , I take back my written permission that I previously
MM/DD/YYYY

gave to The Harris Center on _____
Date of authorization to be revoked

to disclose to/receive from: _____
Person/organization named on authorization to be revoked

health information about me. I understand that from today forward my health information will no longer be disclosed to the above noted person/organization unless I give my written permission.

_____ _____
Individual/Patient or Legally Authorized Representative (LAR) Signature Date

_____
Printed name of the LAR

_____
LAR's Relationship to Individual/Patient (attach supporting documentation)