

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](mailto:ROICoordinator@TheHarrisCenter.org) or Facsimile: (713) 970-3817.

Thank you,

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