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,
AUTHORIZATION TO DISCLOSE CONSUMER HEALTH INFORMATION

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

I hereby authorize: ________________________________

The Harris Center

To disclose to ________________________________

Name (Print): ________________________________

To receive from ________________________________

Pickup _______ Mail _______

Street Address ________________________________

City, State, Zip ________________________________

Phone and/or Fax ________________________________

City/State/Zip ________________________________

Phone and/or Fax ________________________________

I hereby authorize:

The Harris Center

To disclose to ________________________________

Name (Print): ________________________________

To receive from ________________________________

Pickup _______ Mail _______

Street Address ________________________________

City, State, Zip ________________________________

Phone and/or Fax ________________________________

City/State/Zip ________________________________

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
- Psychological Evaluation
- Psychiatric Evaluation
- HIV Information
- Other—specify:

- Medical History
- Service/Treatment Plans
- Medications Prescribed
- Diagnosis
- Discharge Summary
- Physicians Orders
- Laboratory Reports
- Progress Notes
- Educational
- Financial/Billing
- Alcohol/drug abuse
- Vocational

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

- Follow-up/Follow-along
- Verification of maintaining appointments
- Determine eligibility-Social Security Disability, etc.
- Residential placement
- Other—specify:

- To aid in treatment planning
- Financial/Insurance verification
- Medication Verification
- Assess/monitor treatment needs
- Continuity of care
- Monitor medical status
- Legal proceedings/Court Updates
- At individual/patient request

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) ________________________________ OR

Representative’s relationship to individual/patient ________________________________

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.

Identity of requestor verified; ________________________________

Paper disclosure processed by: ________________________________

Staff Printed Name/Initial/Date ___________

Signature/Date ___________

Known to me ________________________________

Authorization revoked on: MM/DD/YYYY ________________________________

And noted by ________________________________

Staff printed name and initials ________________________________

See signed revocation on reverse side.

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

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)