



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.
- **If you believe this request contains substance abuse or HIV Information please check those boxes or we cannot process your request.**

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 PATIENT/INDIVIDUAL HEALTH INFORMATION

Individual/Patient (Print)	Date of Birth	SS# or Case Number	Medicaid #
I hereby authorize:			
<input type="checkbox"/> To disclose to <input type="checkbox"/> 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, 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 understand further 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.

TPO Consents:

I understand that if the recipient of this use or disclosure is a covered entity or business associate, my record (or information contained in the record) may be redisclosed for treatment, payment, or healthcare operations in accordance with the permissions contained in the HIPAA regulations and 42 CFR Part 2 and may be no longer protected. This authorization excludes uses and disclosures for civil, criminal, administrative, and legislative proceedings against me.

I understand that consent to share information for TPO can be made a condition of receiving care, provided the agency has the capacity to accommodate any restrictions I may request on uses and disclosures.

Restriction Request: Individual _____ Information _____

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

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

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Assessments | <input type="checkbox"/> Medical History | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Educational | <input type="checkbox"/> Financial/Billing |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Service/Treatment Plans | <input type="checkbox"/> Physicians Orders | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Medications Prescribed | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Alcohol/drug abuse | |
| <input type="checkbox"/> HIV Information | <input type="checkbox"/> Vocational | <input type="checkbox"/> Other-specify: _____ | | |

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

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Follow-up/Follow-along | <input type="checkbox"/> Residential placement | <input type="checkbox"/> Continuity of care | <input type="checkbox"/> Legal proceedings/Court Updates |
| <input type="checkbox"/> Financial/Insurance verification | <input type="checkbox"/> Individual /Patient request | <input type="checkbox"/> Medication Verification | <input type="checkbox"/> Assess/monitor treatment needs |
| <input type="checkbox"/> Determine eligibility-Social Security Disability, etc. | <input type="checkbox"/> To aid in treatment planning | <input type="checkbox"/> Verification of maintaining appointments | |
| <input type="checkbox"/> Treatment, Payment, Healthcare operations | <input type="checkbox"/> 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 _____ No Expiration Date (TPO only)

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)

Signature/Date	Identity of requestor verified;	Paper disclosure processed by: _____
	<input type="checkbox"/> Picture ID <input type="checkbox"/> Signature <input type="checkbox"/> Known to me	Staff Printed Name/Initial/Date



**REVOCAION OF AUTHORIZATION TO DISCLOSE
PATIENT/ INDIVIDUAL 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)