



Authorization to Release Information

I, (name of client) _____ hereby authorize Dr. Yasmeen Khan/Dr. Asif Khan to disclose mental health information and records obtained in the course of my treatment, including but not limited to Dr. Khan's diagnosis to:

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have a right to revoke this authorization at any time unless Dr. Khan has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Dr Khan at his/her office to be effective. This disclosure of information and records authorized by client is required for the following purpose:

The specific uses and limitations of the types of medical information to be discussed are as follows: (be as specific as you choose to)

Such disclosure will be limited to the following specific types of information:

Therapist shall not condition treatment upon clients signing this authorization and client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Rule, although applicable Illinois law may protect such information.

This authorization shall remain valid till _____

Client's Signature: _____ Date: _____