<u>Authorization to Release Information</u>

I, (name of client)_______________________ hereby authorize Dr. Munira Merchant to disclose mental health information and records obtained in the course of my treatment, including, but not limited to Dr. Merchant'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 evoke this authorization at any time unless Dr. Merchant has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Dr. Merchant at 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 e 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: _________________