AZITA AFSHAR, PSY.D.

Authorization Form

This form, when completed and signed by you, authorizes me to release protected information from your clinical records to the person you designate.

I authorize Azita Afshar, Psy.D. to release or receive information about:_____

This information can only be released to or received from (name and address of person to whom the information is to be released):

_____

_____

_____

I am requesting Azita Afshar, Psy.D. to release/receive this information for the following purposes: ("at the request of the individual" is all that is required if you are my patient or the parent/guardian of my patient unless you desire to state a specific purpose).

_____

_____

This authorization shall remain in effect From:_____ Until: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action to reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer maintains a legal right to consent a claim.

I understand that Azita Afshar, Psy.D. may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating healthy information to a third party.

I understand that I have the right to inspect the disclosed mental heath information at any time.I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure.

Patient signature: _____ Date: _____