Shifa Psychiatry, Inc.
31480 Highway 45
Libertyville, IL. 60048
Phone: 847-680-2715
Fax: 847-680-3832

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

RE:____

I authorize and request that:

AGENCY OR INDIVIDUAL:

Name: ____________________________________

Address: ____________________________________

City, State, Zip: ______________________________

Phone Number: ______________________________

Fax Number: ________________________________

Release confidential protected information including: personal. Psychiatric, medical, laboratory, psychological testing, social, educational, substance abuse, clinical information and opinions regarding myself and (if applicable) re-release of __________________.

TO: **Shazia Tayyab, M.D.**

Dr. Tayyab is likewise authorized to release said information to above party **YES/NO**

This authorization is valid for 12 months from date of signing and limited to only that information that I have requested above to be released to the person named herein. The purpose of this release of information is to assist in providing complete care. All information can be inspected by and copied by the client. It is understood that I have the right to revoke the consent (in writing) contained at any time during its validity.

I understand that my refusal to consent of the release of information specified above will prevent disclosure of such material to the person/attorney deposition named herein, with the potential consequences of reduced accuracy and completeness of my care.

____
Signature of patient (if over 12 years)

____
Signature of Parent Guardian (if under 18 years)

____
Date

____
Signature of Witness