Alliance Psych Services
Farid Karimi, MD. PC
11235 Distinctive Dr
Orland Park, IL 60467
Office 708-479-5555 / Fax 708-479-5055

I, _____, authorize Farid Karimi, MD PC/Alliance Psychiatric Services, 11235 Distinctive Dr, Orland Park, IL 60467. Phone 708-479-5555 and/or any of its providers to disclose to and/or obtain from:

_____ [Insert Name of Person or Title of Person or Organization]

Address: _____
_____

Phone: _____ Fax: _____
the following information:

(Patient / Client should **INITIAL** each item to be disclosed)

_____ All mental health information / records, including but not limited to progress notes, assessments, psychological testing results, lab results, treatment plans, correspondence, substance abuse treatment information, HIV/AIDS-related information, demographic information, medication management information.

_____ Treatment Plan
_____ Treatment Updates
_____ Presence / Participation in Treatment
_____ Psychological / Psychiatric Assessment Results
_____ Re-disclosure of the following protected health information.
_____

Purpose of this disclosure: ☐ Coordination of Care ☐ Family Participation in Treatment
☐ Disability ☐ Other: _____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization. If not previously revoked, this authorization will termination on the following date: _____

If no date is specified, this authorization will expire after 60 days.

I understand that my treatment is not conditioned on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: No information will be disclosed.

I understand that if the entity receiving this information is not a healthcare provider / plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

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The protected health information that is disclosed pursuant to this authorization may only be re-disclosed by the recipient as permitted by federal and Illinois State laws.

Form of Disclosure

Unless specifically requested in writing that the disclosure be made in a certain format, information disclosed pursuant to this authorization many be made in any manner that deemed to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Alliance Psych Services / Farid Karimi, MD. PC and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I Understand that I am entitled to a copy of this authorization.

_____ Date: _____
Signature of Patient (age 12 years or older)

_____ Date: _____
Signature of Parent or Guardian (under age 18 years or disabled)

Witness: _____ Date: _____

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____ City/State: _____

Zip Code: _____