Zabrin Inan, MD
Consent for Release of Information

Patient's Name_____

Date of Birth_____Social Security Number_____

I hereby give permission to Zabrin Inan, MD to:

☐ Disclose information to: ☐ Obtain information from:

Individual's Name_____

Organization's Name_____

Street Address_____

City_____State_____Zip_____

Home Phone_____Work Phone_____Cell_____

Please Disclose:
(Check ONLY information you wish to disclose to this individual or organization)

- ☐ Diagnostic Information
- ☐ Current Medication
- ☐ Psychotherapy Notes
- ☐ Treatment of Discharge Summary
- ☐ Verbal Information
- ☐ Psychological Testing Report
- ☐ Alcohol and Drug Abuse Diagnosis and Info
- ☐ HIV/AIDS Diagnosis and Information
- ☐ Lab Results:_____
- ☐ Other:_____

Purpose of this disclosure:_____

Please send the requested information to:
Zabrin Inan, MD | 233 East Erie St., Suite 600 | Chicago, IL 60611

I consent to the release of the information indicated above. I understand the release of this information will occur in accordance with governing federal and state statutes and only a patient has the right to authorize release of information. This consent will automatically expire six months from the date of my signature and I may revoke this authorization, in writing, at any time. A photocopy or fax copy of this authorization shall be as valid as the original. NOTE: You must clearly indicate each person that will be allowed access to this information.

Patient's Signature_____Date_____

Print Name_____Date_____

Parent/Guardian Signature_____Date_____

Print Name_____Date_____

Signature of Witness_____Date_____

Print Name_____Date_____

233 East Erie St., Suite 600 | Chicago, IL 60611
312.952.3054 | 312.280.8854 Fax
dr.inan@sbcglobal.net | www.zabrininanmd.com