15419 127th Street, Suite 5
Lemont, IL 60439
630.777.7113 (Telephone)
630.243.0317 (Fax)

I hereby authorize Reem K. Cutinello and/or counselors of Finding Balance, ltd. to use or disclose the specific information described below and only for the purposes and parties as so described below:

Description of the specific information to be used or disclosed:
information related to client progress, educational, medical, physical and emotional status and other pertinent information related to client well-being for treatment purposes.

Persons or entity requesting the information and authorized to make the requested use or disclosure:

Recipient of information: _____

The information is being requested for the following purpose(s):
Most effective treatment purposes via collaboration.

This authorization shall remain in effect from the date signed below until _____ expiration date or event

I understand that:

- ☐ I may inspect or copy the protected health information to be used or disclosed
- ☐ I may revoke this authorization in writing by contacting your office at the address above
- ☐ Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA
- ☐ I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).
- ☐ I understand that you will receive compensation from a third party for the use or disclosure of my information

Patient Name	Patient Signature	Date
Parent of child or adolescent patient	Parent Signature	Date