CHICAGO CENTER FOR WELL-BEING, INC
230 E Ohio Street, #705 Chicago, IL 60611 tel: + 1 312 539 3345

AUTHORIZATION FOR RELEASE/DISCLOSURE
OF INFORMATION

Authorization: I, ________________________________, with a birth date of ____________ ("Client"), voluntarily consent to authorize Marko Mihailovic, LCPC with a principal place of business at 230 East Ohio Street, Suite 705, Chicago, Illinois 60611 ("Marko Mihailovic") and the party identified below ("Collaborator"), to use, obtain, disclose, re-quest, release, and/or discuss my health information, including but not limited to all relevant mental health information, in the possession or control of Marko Mihailovic and/or Collaborator ("collectively "Information''). Marko Mihailovic and/or Collaborator may obtain, disclose, request, release, and/or discuss in tangible form (e.g. via email or mail) and/or in intangible form (e.g. phone calls).

Collaborator:

Name: ____

Address: ____

Phone: ___________________________ Email: _______________________

Purpose: I authorize the release of my Information for the following specific purpose:

____

Information to be disclosed: I authorize the release of the following Information: (check all applicable boxes below)

All of my records and/or Information that Marko Mihailovic and/or Collaborator has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

Only the following records or types of Information

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Records and/or Information related to transmittable diseases, including HIV.

Records and/or Information related to drug and/or alcohol use and/or treatment.

Records and/or Information related to mental health.

I understand that I have the right to inspect the Information released by Marko Mihailovic.

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Term: I understand that this authorization will remain in effect:

From date ____________________through date _______________________

Until the following event occurs: _____________________________________

Redisclosure: I understand that Marko Mihailovic cannot guarantee that the Collaborator will not redisclose my Information to a third party. Collaborator may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my In-formation. Marko Mihailovic is not responsible for the actions of Collaborator or any other party who may be provided with the Information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I do not sign, it will not affect the commencement, continuation or quality of my treatment with Marko Mihailovic except to the extent that the Information in the possession of Collaborator may assist Marko Mihailovic in determining appropriate treatment. If I change my mind, I under-stand that I can revoke this authorization by providing a written notice of revocation to Marko Mihailovic to her address listed above. My revocation will be effective immediately upon Marko Mihailovic's receipt of my written notice, except that my revocation will not have any effect on (i) any action taken by Marko Mihailovic in reliance on this authorization before she received my written notice of revocation or (ii) if this authorization was obtained as a condition of obtaining insurance coverage, my insurer's legal right to contest a claim.

I hereby acknowledge and agree to the terms and conditions of this authorization.

____
Client (or Authorized Representative) Printed Name

____
Client (or Authorized Representative) Signature

____
Date

If Client is unable to sign this authorization, please complete the information below:

______________________________	________________	__________
Name of Guardian/ Representative	Legal Relationship	Date