



# Client Authorization Form

I, \_\_\_\_\_, whose Date of Birth is \_\_\_\_\_,  
authorize Legacy Clinical Consultants, LLC to disclose to and/or obtain from: \_\_\_\_\_

the following information:

## Description of Information to be Disclosed

*(Client should initial each item to be disclosed)*

- |  |  |
|--|--|
| <input type="checkbox"/> Assessment                  | <input type="checkbox"/> Drug Screen                             |
| <input type="checkbox"/> Diagnosis                   | <input type="checkbox"/> Educational Information                 |
| <input type="checkbox"/> Psychosocial Evaluation     | <input type="checkbox"/> Discharge Summary                       |
| <input type="checkbox"/> Psychological Evaluation    | <input type="checkbox"/> Continuing Care Plan                    |
| <input type="checkbox"/> Psychiatric Evaluation      | <input type="checkbox"/> Progress in Treatment                   |
| <input type="checkbox"/> Treatment Plan or Summary   | <input type="checkbox"/> Presence/DOS/Participation in Treatment |
| <input type="checkbox"/> Current Treatment Update    | <input type="checkbox"/> Demographic Information                 |
| <input type="checkbox"/> Medication Management Info. | <input type="checkbox"/> Other _____                             |

## Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify: \_\_\_\_\_

## Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Lynette Van Meter at 13242 South Route 59, Suite 107, Plainfield, IL 60585, 630.527.1664 ext. 100. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

## Expiration

Unless sooner revoked, this consent expires on the following date: \_\_\_\_\_ or  
as otherwise indicated: \_\_\_\_\_.

If a calendar date is not stated, information may only be released on the date the authorization is received.

## Conditions

I further understand that Legacy Clinical Consultants, LLC will not condition my treatment 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 \_\_\_\_\_  
\_\_\_\_\_

## Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including but not limited to, verbally, in paper format or electronically.

## Redisclosure

State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 of the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et. seq.).

I understand that I have the right to inspect and copy the information to be disclosed. Upon request I will be given a copy of this authorization for my records.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Check here if client refuses to sign authorization.

\_\_\_\_\_  
Signature of Staff Witness Attesting to Identify & Authority

\_\_\_\_\_  
Date