Transforming Lives, Impacting the Future

Legacy Clinical Consultants, LLC

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)

- ☐ Assessment
- ☐ Psychological Evaluation
- ☐ Current Treatment Update
- ☐ Educational Information
- ☐ Progress in Treatment
- ☐ Other _____
- ☐ Diagnosis
- ☐ Psychiatric Evaluation
- ☐ Medication Management Information
- ☐ Discharge Summary
- ☐ Presence/Participation in Treatment
- ☐ Psycho-social Evaluation
- ☐ Treatment Plan or Summary
- ☐ Drug Screen
- ☐ Continuing Care Plan
- ☐ Demographic Information

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 **Legacy Clinical Consultants** at 3033 Ogden Ave., Suite 210, Lisle, IL 60532 (877.443.7030 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 one year from the signature date. Or as otherwise indicated:

_____

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 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 1, 10/1 et seq.)

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

_____	_____	_____	_____
Signature of Client	Date	Signature of Parent, Guardian or Personal Representative *(if client is under age 18)*	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