Legacy Clinical Consultants, LLC

Transforming Lives, Impacting the Future

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
- ☐ Diagnosis
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Update
- ☐ Medication Management Info.
- ☐ Drug Screen
- ☐ Educational Information
- ☐ Discharge Summary
- ☐ Continuing Care Plan
- ☐ Progress in Treatment
- ☐ Presence/DOS/Participation in Treatment
- ☐ Demographic Information
- ☐ 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.

13242 South Route 59 • Suite 107 • Plainfield, IL 60585 • 630.527.1664 ext. 100

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 1 10/1 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