

(800) LAP 1233 or (312) 726-6607

Fax: (312) 726-6614

20 S Clark St, Suite 1820

Chicago, IL. 60603

# Illinois Lawyers Assistance Program

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| I,  |   | **,** do hereby consent to and authorize **THE ILLINOIS** |
| **LAWYERS ASSISTANCE PROGRAM** (LAP) to disclose to: |

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|  |

 **(Person/Institution)**

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 **(Address, City, State, Zip)**

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 **(Telephone) (Fax)**

Information in its possession relating to my identity, diagnosis, prognosis or treatment. I understand that the specific type of information to be disclosed includes:

X Participation in the LAP X Monitoring/Aftercare Agreement X Compliance with Agreement X Written/Verbal Contact

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|  X Diagnosis | [ ]  Other (Please Specify)  |       |

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| Purpose or Need for Data: | case management and advocacy |

**Special Authorization for Release of** **[ ]  Mental Health and Alcohol or Drug Abuse Case Management/Patient Records/ [ ]  HIV**

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| I further Authorize the Person/Institution named above to **release to the Illinois LAWYERS ASSISTANCE Program** the following information**:** |

[ ]  Multidisciplinary Assessment [ ]  Diagnosis [ ]  Discharge Summary

[ ]  Psychiatric and Psychological Evaluation [ ]  History and Physical [ ]  Laboratory Reports

[ ] Treatment Plan [ ]  Treatment Compliance [ ]  Progress

[ ]  Medications [ ]  Toxicology Results [ ]  Monitoring Agreement

[ ]  Work Performance/Behavioral Concerns [ ]  Toxicology Compliance [ ]  Legal/Licensure Status

[ ]  Status with Program [ ]  Written/Verbal Contact

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| [ ]  Other (Please Specify): |       |

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| **Date:** |       |  | **DOB:** |       | / |       | / |       |

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| **Signature of Participant:** |  |

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 **(Address, City, State, Zip)**

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| **Witness:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |       |

*It is understood that this authorization is subject to revocation by me at any time in writing except to the extent that action has already been taken to release this information*. **This authorization shall remain valid until revoked and will expire**     ***/***      ***/***      ***.*** It is understood that if I do not sign this authorization, the institution named above will not release my medical records.

Phone Numbers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_