

(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

|  |  |
| --- | --- |
| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_