



INTERSTATE SERVICES CONSENT FOR AN INTERSTATE TRANSFER

TYPE OF ADMISSION	
<input type="checkbox"/> Voluntary	<input type="checkbox"/> Other
<input type="checkbox"/> Emergency	<input type="checkbox"/> Competent
<input type="checkbox"/> Court Order	<input type="checkbox"/> Incompetent
(also give Docket Number)	

I am presently an individual receiving services at the: _____
(Name of facility)

(Address)

I request that a referral be made on my behalf to the State of _____ where my close relatives reside and/or where I consider myself to have residence. I have been informed that this facility believes I would derive clinical benefits from such transfer. I, therefore, agree and give my consent to a referral for an interstate transfer. I understand this facility will let me know the decision of the State to which the referral has been made. To initiate such transfer request, I understand it is necessary that I consent to the release of information from my records to the Interstate Compact Coordinator of Illinois or his or her designee and redisclosure to the State of _____ and any of its agents, for the purpose of that State's evaluation of this transfer request. I understand that the State of _____, may in its discretion redisclose information provided to my relatives in the transfer request. There will be no redisclosure, except under the abovecircumstances, without my written consent. I understand the information to be released may include admission summary; social and residence history; psychological, psychiatric, medical and behavioral reports; individualized education plan; habilitation plan; type and dosage of medication; names and addresses of relatives; social security number; medicare and/or medicaid number; and type of source of income. I also understand that by executing this form, I am not waiving my rights as defined under the Illinois Mental Health and Developmental Disabilities Code [405 ILCS5].

This form has been provided to me in language I can understand and I fully understand its nature and contents. I have willingly and voluntarily signed this form. I confirm it is my desire that this referral for an interstate transfer be submitted. I also understand that if my request is approved and authorized that I am voluntarily consenting to be admitted to a State-operated mental health or developmental center or aftercare or community residential placement setting in the State of _____

This authorization expires upon completion of the transfer review process resulting in the denial or approval of my request. However, I understand I may withdraw this authorization and consent for transfer, in writing, at any time prior to the scheduled departure time on the transfer date. I also understand that the Department has the right to seek an order from the circuit court approving the transfer, if the State to which referral was made grants transfer authorization and I then revoke my consent.

To be signed by two witnesses:

Name of witness: _____ Title: _____

Name of witness: _____ Title: _____

Address: _____

Address: _____

Date: _____

Date: _____

Individual's Signature*: _____

Date: _____

Facility Name: _____

Facility address: _____

NOTE: Facility must attach to this form a completed and signed "Authorization for Release of Information" (IL462-0146)



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* If signature is not of the individual, indicate relationship and legal basis on which consent is given for the individual. If legal guardian, include copy of court order of appointment.

A copy of this form was provided to the individual or his/her authorized representative in:

English Spanish Other (specify) _____ by

_____ on _____
(Name) (Title) (Date)