LEGAL SERVICES REFERRAL FORM & INFORMED CONSENT RELEASE

I ____(please print), hereby authorize:

(____) ROCHESTER REGIONAL HEALTH (RRH), or any of its agents, employees, or assignees to release limited information concerning all of my household members to Legal Assistance of Western New York, Inc.®. The purpose of this information sharing is to make referrals for legal assistance. I understand that the limited information shared by RRH may include my name, address, phone number, date of birth, health insurance information, and nature of the legal issue.

(____) LEGAL ASSISTANCE OF WESTERN NEW YORK, INC.®, or any of its agents, employees, or assignees to release limited information concerning all of my household members to Rochester Regional Health. The purpose of this information sharing is to maintain data regarding characteristics and services provided to clients as well as benefits to the hospital after legal intervention. I understand that the limited information shared with RRH may include my name, date of birth, health insurance information, nature of the legal issue, and disposition of the legal case.

(____) I have the right to terminate this Release of information at any time in writing.

A photocopy of this authorization shall have the same full force and effect as the original.

Signature: __________________________________ Date: _________________

REFERRER SECTION Referrer name, contact info____

Reason for referral____

____

Contact person_____________________________________Patient (if different)__________________________

Contact person phone_______________________________ Relationship to patient________________________

FAX COMPLETED FORM TO 585-325-2559 OR EMAIL COMPLETED FORM TO fllc@lawny.org

Questions? Leave a message at 585-922-4938

ROCHESTER REGIONAL HEALTH