FINGER LAKES LEGAL CARE

FLLC

A PROJECT OF LawNY®

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.

(____) 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 Volunteer Legal Services Project of Rochester, Inc.. The purpose of this information sharing is to make case referrals when appropriate. I understand that the limited information shared by Legal Assistance of Western New York, Inc.® may include contact, demographic, and financial information as well as your date of birth, social security number, health insurance information, and nature of the legal issue.

(____)VOLUNTEER LEGAL SERVICES OF ROCHESTER, INC., 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.® to maintain data regarding characteristics and services provided to clients as well as survey data. I understand that the limited information shared with Legal Assistance of Western New York, Inc.® may include my name, address, date of birth, health insurance information, nature of the legal issue, disposition of the legal case, and survey data. Survey data will be used to evaluate patient reported health status following legal intervention.

(____) 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

Questions? Leave a message at 585-922-4938