LAND OF LINCOLN -LEGAL AID-
Breaking Barriers to Justice

SIH

MEDICAL LEGAL PARTNERSHIP *of southern Illinois*

- ❑ Harrisburg Medical Center
- ❑ Herrin Hospital
- ❑ Memorial Hospital of Carbondale
- ❑ St. Joseph Memorial Hospital

- ❑ Cancer Institute
- ❑ Center for Medical Arts
- ❑ Logan Primary Care
- ❑ Primary Care Harrisburg
- ❑ SIH Medical Group Other: _____

Shawnee | Health

- ❑ Shawnee Alliance/Healthy Families

- ❑ Shawnee Health - Carbondale
- ❑ Shawnee Health - Carterville
- ❑ Shawnee Health - Marion
- ❑ Shawnee Health – Murphysboro

- ❑ Shawnee Behavioral Health
- ❑ Shawnee OB/GYN & Pediatrics
- ❑ Shawnee Health Other: _____

Patient Information Referral Form

Emergency? (Select Option)

***ICD10**/Diagnosis*:

*Patient of an **SIH Hospital** or **SIH Medical Group***: (Select Option)

Patient Name (first, middle, last):

DOB: SS# (last four digits):

E-mail: *Safe to Send Message:* (Select Option)

Home Address:

Safe to Send Mail: (Select Option)

City: Zip:

Phone #: *Safe to Leave Message:* (Select Option)

Permission to Send Text Message: (Select Option)

Referred By: _____

Phone: _____ Ext: _____

E-mail: _____

LEGAL CATEGORY (Please Check)	INCLUDES (Please check)
☐ **Criminal Records**	Expungement ☐ Sealing ☐ Healthcare worker waivers ☐ Certificates of good conduct/rehabilitation ☐
☐ **Consumer Protection**	Debt Collection ☐ Bankruptcy ☐ Consumer fraud ☐
☐ **Education Law**	Education issues for disabled children ☐ Discipline, suspension and termination from school ☐
☐ **Elder Law & Disability Rights**	Elder abuse and exploitation ☐ Advance directives ☐ Wills ☐
☐ **Housing**	Eviction ☐ Unsafe living conditions ☐ Foreclosure ☐
☐ **Family Safety & Stability**	Orders of Protection ☐ Divorce ☐ Custody ☐ Guardianship (child, disabled adult) ☐
☐ **Public Benefits**	Medicaid ☐ Medicare ☐ TANF ☐ SNAP ☐ Social Security ☐ Unemployment ☐

Brief Description:

_____

_____

PATIENT AUTHORIZATION TO DISCLOSE THE FOLLOWING HEALTH/LEGAL INFORMATION

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I authorize the health care provider named above to consult with Land of Lincoln Legal Aid (Land of Lincoln) about my possible legal problem to see if Land of Lincoln can help resolve my problem or refer me to other resources. I also authorize Land of Lincoln to discuss my possible or current legal problem with my health care provider to help resolve my problem. I further authorize Land or Lincoln to disclose, my name, demographic information, and result of my case to the above-named healthcare provider and Southern Illinois Healthcare.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department and Land of Lincoln. I understand that the revocation will not apply to information that has already been released in response to this authorization or to the extent that Land of Lincoln has already acted in reliance on this authorization.

I understand that the information (excluding mental health information) that is being disclosed under this authorization may be subject to re-disclosure by the recipient and no longer be protected under the Health Insurance Portability and Accountability Act.

I understand that this authorization may include disclosing information regarding mental health, developmental disability, sexually transmitted disease, alcohol and/or drug abuse services, and HIV/AIDS test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize disclosure of the information between the healthcare provider listed above and Land of Lincoln. I agree that that a photocopy of this authorization is as valid as the original

Client's Signature **Date**

Legal assistance is not provided for criminal or personal injury cases.
Representation is not guaranteed and is determined on a case by case basis

PLEASE SEND TO:
Land of Lincoln Legal Aid: Attention Intake Specialist mlpsi@lincolnlegal.org
Fax: (618) 457-7877 **Phone: (618) 457-7800 ext. 6127**

SIH STAFF: Please also send to:
mhc.healthinfo@sih.net AND linda.mcminn@sih.net