



LAND OF LINCOLN -LEGAL AID-  
Breaking Barriers to Justice



# MEDICAL LEGAL PARTNERSHIP of southern Illinois

Updated: 07/23/2019



- Herrin Hospital
- Memorial Hospital of Carbondale
- St. Joseph Memorial Hospital

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



- Shawnee Alliance / Healthy Families

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- Shawnee Health Care-Carbondale
- Shawnee Health Care- Carterville
- Shawnee Health Care-Marion
- Shawnee Health Care- Murphysboro

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- Shawnee Healthcare – Behavioral Health
- Shawnee Health Care – OB/GYN & Pediatrics
- Shawnee Health Service Other:

<b>Patient Information Referral Form</b>		<b>Emergency? Yes / No</b>
<b>ICD10 / Diagnosis:</b> _____		
<b>Patient of an SIH Hospital or SIH Medical Group:</b> Yes / No		
<b>Patient Location at time of referral:</b> Home, SIH Hospital, LTC Facility Other: _____		
<b>Patient Name</b> (first, middle, last): _____		
<b>DOB:</b> _____	<b>SS#</b> (last four digits): _____	
<b>E-mail:</b> _____		<b>Safe to Send Message:</b> Yes / No
<b>Home Address:</b> _____		
<b>City:</b> _____	<b>Zip:</b> _____	<b>Safe to Send Mail:</b> Yes / No
<b>Phone #:</b> _____		<b>Safe to Leave Message:</b> Yes / No
<b>Permission to Send Text Message:</b> Yes / No		
<b>Referred By:</b> _____		
<b>Phone:</b> _____		<b>Ext:</b> _____
<b>E-mail:</b> _____		

<b>LEGAL CATEGORY</b> (Please Check)	<b>INCLUDES</b> (Please Circle)
<input type="checkbox"/> <b>Criminal Records</b>	Expungement    Sealing    Healthcare worker waivers    Certificates of good conduct/rehabilitation
<input type="checkbox"/> <b>Consumer Protection</b>	Debt collection    Bankruptcy    Consumer fraud
<input type="checkbox"/> <b>Education Law</b>	Education issues for disabled children    Discipline, suspension and termination from school
<input type="checkbox"/> <b>Elder Law &amp; Disability Rights</b>	Elder abuse and exploitation    Advance directives    Wills
<input type="checkbox"/> <b>Housing</b>	Eviction    Unsafe living conditions    Foreclosure
<input type="checkbox"/> <b>Family Safety &amp; Stability</b>	Orders of protection    Divorce    Custody    Child guardianships
<input type="checkbox"/> <b>Public Benefits</b>	Medicaid    Medicare    TANF    SNAP    Social Security

**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

[mjpsi@lincolnlegal.org](mailto:mjpsi@lincolnlegal.org)

**Fax: (618) 457-7877**

**Phone: (618) 457-7800 x 6127**