McLaren Print System Order

Order No: 41806 Reprint Previous Order No: 26288
Order Date: 2019-01-10
User: Victoria Tijerina
Phone: 5173031371

Ship Location: Portland Family Care
**   406 Kent St**
**   Portland , MI 48875**
Forms
Quantity: 100
Paragon Dept No: 54508
Dept Name: Portland Family Care
Company Number: 810

Order Total Price: 0.00

Item Number: MM-336
Item Description: Authorization to Release Information to Family/Friend
Revision Date: 10/2017
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info:

McLaren Medical Group

Authorization to Release Information to Family/Friend

Patient Name _____   Date of Birth _____

I authorize my health care providers to disclose and release my protected health information described
below to:

Name _____ Phone Number _____ Relationship _____
Name _____ Phone Number _____ Relationship _____
Name _____ Phone Number _____ Relationship _____

Specific type of information for disclosure:

_____   My entire medical record (including mental health records, communicable diseases including
        HIV/AIDS, alcohol/drug abuse treatment, etc)

_____   Specific disclosures _____

_____   Specific restrictions _____

I authorize my provider to disclose to my family/friends in the following format(s):

_____   Verbal

_____   Paper copy

_____   Electronic copy

This authorization is in effect until (date or event) _____

I may revoke this authorization at any time in writing. Otherwise, this authorization will automatically
revoke at the end of the date or event as specified above.

I understand that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on my
signing this authorization.

I understand that any disclosure to an individual made from this authorization carries with it the
potential for that individual to disclose the information and that once a disclosure is made under this
authorization that it is no longer protected by federal and state confidentiality laws.

By signing this form, I confirm that I understand the information and any questions I have were
answered.

Patient or Legal Representative Signature _____   Date/Time _____