McLaren Business Products

McLaren Print System Order

Order No: 42012 Reprint Previous Order No: 26288
Order Date: 2019-01-16
User: Sarah Paine
Phone: 248 656 0472

Ship Location: McLaren Oakland Family Medicine
1240 South Lapeer Road Suite 101A
Lake Orion, MI 48360
Forms
Quantity: 100
Paragon Dept No: 73200
Dept Name: McLaren Oakland Family Medicine
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 _____