

**McLaren Print System Order**

**Order No: 42596 Reprint Previous Order No: 6293**  
**Order Date: 2019-02-05**  
**User: Barbara Payne**  
**Phone: 586.493.3276**

**Ship Location: McLaren Macomb**  
**1030 Harrington Blvd. Suite 206**  
**Mount Clemens, MI 48043**

**Forms**

**Quantity: 100**  
**Paragon Dept No: 60340**  
**Dept Name: Center for Osteopathic Medicine**  
**Company Number: 260**

**Order Total Price: 0.00**

**Item Number: 17418**  
**Item Description: Authorization to Release Information (this is a corporate wide form c/o Medical Records)**  
**Revision Date: 4/28/2015**  
**Print: 2 sided black and white**  
**Paper: 20# White Text**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish:**  
**Drill: None**  
**Misc Info:**

**McLAREN HEALTHCARE**  
**Authorization to Release Information**

Patient Name \_\_\_\_\_ Ethnicity \_\_\_\_\_ Medical Record Number \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ Insurance/Other Payers \_\_\_\_\_

I authorize \_\_\_\_\_ to release to \_\_\_\_\_  
(Name) (Name)  
\_\_\_\_\_ (Address)  
\_\_\_\_\_ (Address)  
City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Telephone/Fax \_\_\_\_\_ Email Address \_\_\_\_\_

Specific type of information to be disclosed: \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_  
 History and Physical  Operative Report  Physician's Notes  
 Consultation Reports  Therapy Notes  Discharge Summary  
 Laboratory Results  Billing Records  Home Care Records  
 Diagnostic Imaging (e.g., X-Ray reports from (date) \_\_\_\_\_  
 Diagnostic Imaging (e.g., X-Ray) films from (date) \_\_\_\_\_  
 Other \_\_\_\_\_

Sensitive information to be disclosed: \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_  
 Behavioral and Mental Health Service Information (including Psychotherapy Notes)  
 Substance abuse/alcohol and substance use disorder  
 Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS-Related Complex)

Consent to release Entire Medical Record, for dates of service listed, including all information noted above.  
Date(s) of Service: \_\_\_\_\_  
\_\_\_\_\_ Date

Please continue to the other side of this form for Acknowledgements and signatures.