

**McLaren Print System Order**

**Order No: 42767 Reprint Previous Order No: 26288**  
**Order Date: 2019-02-08**  
**User: Katie Jacobs**  
**Phone: 9898263271**

**Ship Location: Primary Care Mio Attn Katie Jacobs**  
**558 Lockwood Lane PO Box 460**  
**Mio, Michigan 48621**

**Forms**

**Quantity: 500**  
**Paragon Dept No: 69230**  
**Dept Name: McLaren**  
**Company Number: 811**

**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 \_\_\_\_\_

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