

## **Business Products**

## McLaren Print System Order

Order No: 43599 Reprint Previous Order No: 26288

Order Date: 2019-03-14 **User: Verna Lee** Phone: 989-370-2708

Ship Location: Standish Family Medicine Attn: Tracey A

4489 M-61

Standish, MI 48658

**Forms** Quantity: 100

Paragon Dept No: 69800

**Dept Name: Standish 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: 3/2019

Print: 1 sided black and white

Paper: 20# White Text

Size: 8.5 x 11 Fold:

Finish: None **Drill: None** Misc Info:



Authorization for Verbal Release of Information to Famil	y Members and Friends
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By signing this form, I am authorizing my health care providers to be involved in **settled** discussions regarding my health care with the family members or friends listed below. This may include test results, diagnoses, treatment options and other information from previous visits or treatment,

NAME OF SAMILY/FREND	PHONE NUMBER	RELATIONSHIP (FAMIL/LITRENE)

The following information has special protection under Michigan law and will be made available to the people for listed elever only if i indicate my approval by initialing the lines below:

\_\_\_\_HNUMOS or after communicable diseases including sexually transmitted diseases, venereal diseases, tubercolonic and legistric.

NOTE: This form does NOT give the people listed above the right to exzess or receive a copy of my medical records or medical information. It is not a consent for treatment. It is not to be used to request restrictions on the sharing of my information.

I understand that I can revoke or cancel this form at any time is writing. This form does not require unless revoked. I understand that any disclosure to an individual made from this authorization carries with it the potential for that individual to their the information and that since a disclosure is made reliable understand that the potential for that individual to their their information and that conformation in one open promoted by federal and state conformation formation that my treatment, payment, enrutiment or eligibility for brenefits is not conditioned on my signing this authorization.

Signature of	Pytiere or Patie	orc's Legal	Representati	Ne
Printed N	terne of Patient	Longol Box	ormantative	