

McLaren Print System Order

Order No: 45065 Reprint Previous Order No: 6293
Order Date: 2019-05-02
User: Melissa Hayes
Phone: 9899535305

Ship Location: Weidman Clinic
3520 N. Woodruff
Weidman, Michigan 48893

Forms

Quantity: 100
Paragon Dept No: 81053175566430
Dept Name: Central Region
Company Number: 810

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 _____ Identification Number _____

I authorize _____ to release to _____
(Name) (Name)
_____ (Address)
(Address) (City, State, Zip)
(City, State, Zip) (County/Parish)
(City/Town/Village) (Postal 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 reports from (date) _____
 Other _____

Sensitive information to be disclosed: _____ **Date(s) of Service:** _____
 Behavioral and Mental Health Service Information (including Psychotherapy Notes)
 Human Immunodeficiency Virus (HIV) 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: _____ **Initials** _____ **Date** _____

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