

**McLaren Print System Order** 

Order No: 46515 Reprint Previous Order No: 26288 Order Date: 2019-06-26 User: tiffany mclaughlan Phone: 5862864880

Ship Location: Mclaren Womens Health northgrove: Tiffany 44200 GARFIELD Clinton Township, Michigan 48038

Forms Quantity: 500 Paragon Dept No: 52043 Dept Name: Mclaren Womens Health Northgrove **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:

Oute of Birth

McLaren HEALTH CARE

Patient Name

## Authorization for Verbal Release of Information to Family Members and Friends

By signing this form, Lam authorizing my health care providers to be involved in **seeded** discussions, regarding, my health care with the family members or friends listed below. This may include test results, diagnoses, treatment splits, and other information from previous oxisits or treatments.

NAME OF TAME/UTREND	PHONE NUMBER	RELATIONSHIP (FAMILY/TREND)

The following information has special protection under Michigan law and will be made available to the people for listed dever only (i) indicate my approval by initialing the lines below: —\_\_\_\_\_\_MN(MIC) or other communicable diseases including sexually transmitted diseases, venereal disease, tobercylosis and hepatitis

- Substance abuse services Mental health services

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NOTE: This form does NOT give the people listed above the right to access 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 records or medical information the sharing of my information.

I understand that I can revolve or cancel this form at any time in writing. This form does not expire unless revolved. I understand that any disclosure to an individual made from this authorization carries with it the patential for that individual is share the information and that since a disclosure is made under this authorization is no longer protected by folders and state confidentially least. Understand that my insufment, payment, envalument or eligibility for benefits is not conditioned on my signing this authorization.

Signature of Patient or Patient's Legal Representative **Date** 

Printed Name of Patient's Logal Representative

File in Patient's Medical Record