

McLaren Print System Order

Order No: 50069 Reprint Previous Order No: 6293  
Order Date: 2019-11-04  
User: Pam Gross  
Phone: 989-460-7409

Ship Location: Vassar Family Medicine  
201 W Huron Rd  
Vassar, MI 48768

Forms

Quantity: 100  
Paragon Dept No: 58900  
Dept Name:  
Company Number: 510

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)  
\_\_\_\_\_ (Telephone/Fax) \_\_\_\_\_ (Telephone/Fax)  
\_\_\_\_\_ (Email Address) \_\_\_\_\_ (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 (HMO) \_\_\_\_\_  
 Diagnostic Imaging (e.g., X-Ray reports from (Cable) \_\_\_\_\_  
 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: \_\_\_\_\_  
\_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_

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