

**McLaren Print System Order**

Order No: 55209  
 Order Date: 2020-07-07  
 User: Denise Maginity  
 Phone: 810-342-5470

Ship Location: BARIATRIC & METABOLIC INSTITUTE/BEECH HILL CENTRE  
 G-3200 Beecher Road, MBI  
 Flint, MI 48532

**Forms**

Quantity: 500  
 Paragon Dept No: 36810  
 Dept Name: BARIATRIC & METABOLIC INSTITUTE  
 Company Number: 60

Order Total Price: 24.90

Item Number: 17418-MK  
 Item Description: Authorization\_for\_Release\_of\_Information (Dr Kia)  
 Revision Date: 5/2019  
 Print: 2 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish: None  
 Drill: 5 Hole Top  
 Misc Info: ds; black & white

**McLAREN HEALTHCARE**  
**Authorization to Release Information**

Patient Name: \_\_\_\_\_ Address: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Extension/Other Number: \_\_\_\_\_

I authorize: **McLaren Bariatric & Metabolic Institute** to release to: **Michael Kia, DO**  
 (Patient) **G-3200 Beecher Rd, Ste MBI** (to: **McLaren Bariatric & Metabolic Institute**)  
 (Address) **Flint, MI 48532** (Address) **G-3200 Beecher Rd, Ste MBI**  
 (City, State, Zip) **Flint, MI 48532** (City, State, Zip)  
 (Phone) **p: 810-342-5470 / f: 810-342-5788** (Phone) **p: 810-342-5470 / f: 810-342-5788**  
 (Referral/Ref) \_\_\_\_\_ (Referral/Ref) \_\_\_\_\_  
 (Special Address) \_\_\_\_\_ (Special Address) \_\_\_\_\_

**Specific type of information to be disclosed:** Date(s) of Service: \_\_\_\_\_ 1 year from signature date.

History and Physical     Operative Report     Physician's Notes  
 Consultation & specialty     Therapy Notes     Discharge Summary  
 Laboratory Results     Billing Records     Health Care Records  
 Diagnostic Imaging (e.g., X-Rays, reports from lab) \_\_\_\_\_  
 Diagnostic Imaging (e.g., MRI, CT, PET, Scan, Ultrasound) \_\_\_\_\_  
 Other \_\_\_\_\_

**Sensitive information to be disclosed:** Date(s) of Service: \_\_\_\_\_

Behavioral and Mental Health Service Information (including Psychotherapy Notes)  
 Referrals and treatment for alcohol 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: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Spec Info:** Please refer to the other side of this form for Acknowledgements and signatures.



\_\_\_\_\_  
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