

McLaren Print System Order

Order No: 55210  
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-MB&MI  
Item Description: Authorization\_for\_Release\_of\_Information  
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 \_\_\_\_\_  
 (name) \_\_\_\_\_ (date)  
 G-3200 Beecher Rd, Ste MBI  
 (address) \_\_\_\_\_  
 Flint, MI 48532  
 (city, state, zip) \_\_\_\_\_  
 (phone) 810-342-5470 / (f) 810-342-5788  
 (fax/extension) \_\_\_\_\_  
 (email 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, Bone 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.

