

## **Business Products**

## McLaren Print System Order

Order No: 58209 Reprint Previous Order No: 26288

Order Date: 2020-11-05 **User: Verna Lee** Phone: 989-370-2708

Ship Location: McLaren Primary Care Rose City

2990 Campbell Rd. Rose City, MI 48654

**Forms** Quantity: 100

Paragon Dept No: 69250

**Dept Name: McLaren Primary Care Rose City** 

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:



HEALTH CARE

Authorization for Verbal Release of Information to Family Members and Frien	١d
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By signing this form, I am authorizing my health care provides to be involved in **settled** discussions regarding my health care with the family members or friends blood below. This may include test results, diagnoses, treatment spitchs, and other information from provious solds or treatment.

NAME OF TAMICS, TREND	PHONE NUMBER	RELATIONSHIP (FAMILITYTEENS)
	-	

The following information has special protection under Michigan law and will be made available to the people for listed elever only if i indicate may approved by initialing the lines below:

—HN/MOS or after communicable diseases including sexually transmitted diseases, venereal diseases, toleroclassis and topositios.

NOTE: This form does NOT give the people listed above the right to assess 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 the sharing of my information.

I understand that I can revoke or cancel this form at any time in writing. This form does not require unless revoked. I understand that are disclosure to an individual made from this authorization carries with it the potential for that individual to their the information and that once a disclosure in made reliable understand that their and once the individual to their thin authorization it is no longer protected by federal and state confidentially line. I understand that my treatment, payment, enrutiment or eligibility for brenefits is not conditioned on my signing this authorization.

Signature of Patient or Patient's Legal Representative Printed Name of Patient's Legal Representative