

**McLaren Print System Order**

**Order No: 59635 Reprint Previous Order No: 6293**  
**Order Date: 2021-01-13**  
**User: Kimberly Smirnes**  
**Phone: 586-466-4810**

**Ship Location: McLaren Macomb Heart Rhythm Treatment Center**  
**21550 Harrington Blvd., Suite C**  
**Clinton Township, MI 48036**

**Forms**

**Quantity: 100**  
**Paragon Dept No: 72400**  
**Dept Name: McLaren Macomb Heart Rhythm Treatment Center**  
**Company Number: 810**

**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 \_\_\_\_\_ Insurance/Other Payers \_\_\_\_\_

I authorize \_\_\_\_\_ to release to \_\_\_\_\_  
(Name) (Name)  
\_\_\_\_\_ (Address)  
\_\_\_\_\_ (Address)  
City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
County/Zip \_\_\_\_\_ County/Zip \_\_\_\_\_  
Telephone/Fax \_\_\_\_\_ 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 other) \_\_\_\_\_  
 Diagnostic Imaging (e.g., X-Ray/CT/MRI from other) \_\_\_\_\_  
 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.