McLaren Medical Group
Authorization to Release Information

Patient Name _____ Birthdate _____ Medical Record Number _____

Address _____

Telephone Number _____ Maiden/Other Names _____

I authorize _____ (name) _____ (address) _____ (city,state,zip) _____ (telephone/fax)

to release to _____ (name) _____ (address) _____ (city, state, zip) _____ (telephone/fax) _____ (email address)

Specific type of information to be disclosed: Date(s) of Service: _____

☐ History and Physical ☐ Operative Report ☐ Discharge Summary ☐ Physician's Notes
☐ Consultation Reports ☐ Therapy Notes ☐ Home Care Records ☐ Entire Medical Record
☐ Laboratory Results ☐ Billing Records
☐ Diagnostic Imaging (e.g., X-Rays) reports from (date) _____
☐ Diagnostic Imaging (e.g., X-Rays) films from (date) _____
☐ Other _____

The purpose and need for disclosure:

☐ Continuation of Care ☐ Personal ☐ Insurance Billing
☐ Legal/Attorney ☐ Prefer not to answer ☐ Other _____

I understand that unless otherwise indicated or specified here, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

I understand that any disclosure of information carries with it the potential for redisclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

I understand that I have a right to revoke this authorization at any time by sending a written revocation to the organization's HIPAA/Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more than 60 days after date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's information is permitted.

I understand that I need not sign this form in order to ensure treatment, payment for treatment, or enrollment or eligibility for health benefits.

_____ Signature of Patient or Legal Representative _____ Date

_____ If Signed by Legal Representative, State Relationship to Patient

_____ Signature of Witness _____ Date