

Business Products

McLaren Print System Order

Order No: 61085 Reprint Previous Order No: 26288

Order Date: 2021-03-18 **User: Tonya Furtah** Phone: 8105618450

Ship Location: MMG-St. Clair Family Practice - Attn: Tonya

1163 St. Carney Drive St. Clair, MI 48079

Forms

Quantity: 500

Paragon Dept No: 66000

Dept Name: MMG-St. Clair Family Practice

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 Rel	ease of Inform	ation to Famil	ly Member	and Friend

By signing this form, I am authorizing my health care providers to be involved in **settled** discussions regarding my health care with the family members or friends listed below. This may include test results, diagnoses, treatment options and other information from previous visits or treatment,

NAME OF TAMICUTRIENS	PHONE NUMBER	RELATIONSHIP (FAMILY/TREND)	
	-		

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 access or receive a copy of my medical records or medical information, it is not a comment for treatment, it is not to be used to request restrictions on

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