McLaren Business Products

McLaren Print System Order

Order No: 41730
Order Date: 2019-01-08
User: shirley liddell
Phone: 810-342-5333

Ship Location: Mclaren OakBridge Center PHP - Shirley Liddell
4448 Oakbridge
FLINT, MI 48532
Forms
Quantity: 500
Paragon Dept No: 43560
Dept Name: Mclaren OakBridge Center PHP
Company Number: 60

Order Total Price: 18.00

Item Number: 17932
Item Description: Authorization to Release Information - Referral Source
Revision Date: 3/2015
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: 5 Hole Top
Misc Info:

McLaren Health Care
Authorization to Release Information-Referral Source

Patient Name ____ Birth Date ____ Medical Record Number ____

Address ____

Telephone Number ____ Maiden/Other Names ____

I authorize McLaren Oakbridge (name) 4448 OakBridge Drive (address) Flint, Michigan 48532 (city, state, zip) (810) 342-5333 (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 ☐Therapy Notes ☐Physician's Notes
☒Consultation Reports ☐Billing Records ☒Entire Medical Record
☐Laboratory Results ☒Discharge Summary
☐Operative Report ☐Home Care Records
☐Diagnostic Imaging (eg X-Rays) reports from (date) ____
☐Diagnostic Imaging (eg. X-Rays) Films/CD from (date) ____
☐Other ____

The purpose and need for disclosure:
☒Continuation of care ☐Personal ☐Insurance Billing
☐Legal/Attorney ☐Prefer not to answer ☒Other Discharge Planning

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 and/or alcohol 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 re-disclosure 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

Spec Info:

benefits.

Signature of Patient or Legal Representative ____ Date ____

If Signed by Legal Representative, State Relationship to Patient ____

Signature of Witness ____ Date ____

Authorization to Release Information -Referral Source