McLaren Business Products

McLaren Print System Order

Order No: 41997 Reprint Previous Order No: 26288
Order Date: 2019-01-16
User: Becky Jurish
Phone: 9898935193

Ship Location: Mclaren Bay Internal Med East
714 S Trumbull
Bay City, MI 48708
Forms
Quantity: 500
Paragon Dept No: 56036
Dept Name: Mclaren Bay Internal Med East
Company Number: 810

Order Total Price: 0.00

Item Number: MM-336
Item Description: Authorization to Release Information to Family/Friend
Revision Date: 10/2017
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info:

McLaren Medical Group

Authorization to Release Information to Family/Friend

Patient Name ______________________ Date of Birth ________

I authorize my health care providers to disclose and release my protected health information described below to:

Name ______________ Phone Number ________ Relationship ________

Name ______________ Phone Number ________ Relationship ________

Name ______________ Phone Number ________ Relationship ________

Specific type of information for disclosure:

____ My entire medical record (including mental health records, communicable diseases including HIV/AIDS, alcohol/drug abuse treatment, etc)

____ Specific disclosures ______________________

____ Specific restrictions ______________________

I authorize my provider to disclose to my family/friends in the following format(s):

____ Verbal

____ Paper copy

____ Electronic copy

This authorization is in effect until (date or event): ______________________

I may revoke this authorization at any time in writing. Otherwise, this authorization will automatically revoke at the end of the date or event as specified above.

I understand that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this authorization.

I understand that any disclosure to an individual made from this authorization carries with it the potential for that individual to disclose the information and that once a disclosure is made under this authorization that it is no longer protected by federal and state confidentiality laws.

By signing this form, I confirm that I understand the information and any questions I have were answered.

Patient or Legal Representative Signature ______________ Date/Time ________