

McLaren Print System Order

Order No: 46779 Reprint Previous Order No: 6293
Order Date: 2019-07-05
User: Alicia Mullett
Phone: 9893932850

Ship Location: MCLAREN OCCUPATIONAL HEALTH
4 Columbus Ave; suite 140
BAY CITY, MI 48708

Forms

Quantity: 500
Paragon Dept No: 65100
Dept Name:
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 _____ Identification Number _____

I authorize _____ to release to _____
(Name) (Name)
(Address) (Address)
(City, State, Zip) (City, State, Zip)
(Telephone/Fax) (Telephone/Fax)
(Email Address) (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 (date) _____
 Diagnostic Imaging (e.g., X-Ray reports from (date) _____
 Other _____

Sensitive information to be disclosed: _____ Date(s) of Service: _____
 Behavioral and Mental Health Service Information (including Psychotherapy Notes)
 Substance abuse/alcohol 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: _____
Initials _____ Date _____

Please continue to the other side of this form for Acknowledgements and signatures.