

McLaren Print System Order

Order No: 49367 Reprint Previous Order No: 6293
Order Date: 2019-10-10
User: Melissa Hayes
Phone: 9899535305

Ship Location: Melissa Hayes
3520 N. Woodruff Rd, PO Box 36
Weidman, Michigan 48893

Forms

Quantity: 100
Paragon Dept No: 810530455566430
Dept Name: Central Region
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 _____ Insurance/Other Payers _____

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 other) _____
 Diagnostic Imaging (e.g., X-Ray/CT/MRI from other) _____
 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.