

McLaren Print System Order

Order No: 6590
Order Date: 2014-10-20
User: Kristin Fudge
Phone: 517-975-3107

Ship Location: MGL Redi Care South / Kristin
6910 South Cedar St
Lansing , Mi 48911

Forms

Quantity: 1000
Paragon Dept No: 67725
Dept Name: MGL Redi Care South
Company Number: 810

Order Total Price: 0.00

Item Number: MM-34216-R
Item Description: Authorization to Release Medical Information (McLaren Redi Care)
Revision Date:
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren Medical Group
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Birth Date: ____/____/____
Patient Address: _____ City: _____ State: _____ Zip: _____
Social Security # _____ Telephone # (____) _____
Maiden or other names: _____
I authorize McLaren Redi Care to release to _____
6910 S. Cedar Street _____
Lansing, MI 48911 _____
(517) 975-3100 _____

health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services). This health information is referred to herein as "Protected Health Information."

Specific information to be disclosed: _____

The purpose and need for such disclosure: _____

(If or mental health records, or records pertaining to HIV infection or AIDS, the above paragraph must include a statement as to how the information to be disclosed is germane to the purpose and need for such disclosure.)

Expiration date or event: _____

You have the right to revoke this Authorization except if action has already been taken in reliance upon this Authorization. You may revoke your Authorization by submitting a request in writing to McLaren Medical Group, ATTENTION: Privacy Officer, 6-1080 N. Salsinger Hwy., Flint, MI 48904.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by the law.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION, I UNDERSTAND THAT TREATMENT OR PAYMENT MAY NOT BE CONDITIONED BASED ON THIS AUTHORIZATION, I AM SIGNING IT VOLUNTARILY. FURTHER, I AUTHORIZE THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE TERMS OF THIS AUTHORIZATION.

Signature (patient): _____ Date: ____/____/____
Printed (patient): _____

Signature (Authorized Representative): _____ Date: ____/____/____
Description of Authorized Representative's authority to sign for the patient: _____

MM-34216-R-2014