## McLAREN HEALTHCARE Authorization to Release Information

Patient Name			Birthdate		Medical Record Number		
Address							
Phone Number			Maiden/Other Nam	ies			
l author	1254 North Main S		Street	to release to	(name)		
		Lapeer, MI 48446 (810) 667-7040 / (810) 667-7066 fax			(address)		
					(city, state, zip)		
					(telephone/fax)		
					(email address)		
Spec	cific ty	pe of inform	ation to be disclos	sed:	I	Date(s) of Service:	_
<ul> <li>Hist ory and Physical</li> <li>Operative Report</li> <li>Consultation R eports</li> <li>Therapy Notes</li> <li>Laboratory Results</li> <li>Billing Records</li> <li>Diagnostic Imaging (e.g., X-R ays) reports fror</li> <li>Diagnostic Imaging (e.g., X-R ays) films from (</li> <li>Other</li></ul>			ate)	nmary cords			
Sens	sitive i		be disclosed:			f Service:	
	□ Referr □ Comm	als and treatmen nunicable disease	Health Service Informat t for alcohol and substa es such as sexually tra nmune Deficiency Sync	nce use disorder	and human immu	nodeficiency virus	
□ Co	onsent	to release <u>E</u>	ntire Medical Rec	<u>ord,</u> for dates o	f service liste	d, including all information noted	above:
Date	(s) of S	Service:					
Buto	(0) 01 0				Initials	Date	
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riedS	e con	timue to the	otherside of thi	S IUTITI IUT ACI	liowieagem	ents and signatures.	



PT.	
MR.#/P.M.	

DR.

## By signing this form I understand:

- 1. That I need not sign this form in order to ensure treatment, payment for treatment or enrollment or eligibility for health benefits.
- 2. My health information may be shared electronically.
- 3. The sharing of my health information will follow state and federal laws and regulations.
- 4. This form does not give my consent to share psychotherapy notes as defined by federal law.
- 5. I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back. 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.
- 6. I should tell all agencies and people listed on this form when I withdraw my consent.
- 7. I can have a copy of this form.
- 8. That unless otherwise indicated or specified here, a request for disclosure or release of my "Entire Medical Record" or health information may include information regarding drug, alcohol or mental health 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).
- 9. That any disclosure of information carries with it the potential for redisclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.
- 10. By signing this form, I confirm that I understand the information and any questions have been answered about this form.

Signature of Patient or Legal Representative

If Signed by Legal Representative, State Relationship to Patient

Signature of Witness

AUTHORIZATION TO RELEASE **INFORMATION** 

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Date

Date

PT.

DB

MR.#/P.M