



BAY REGION

**SUNRISE MEDICAL CLINIC**

618 Mulholland Street, Bay City, MI 48708

# Fax Cover Sheet

Date: \_\_\_\_\_ Time: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_ Department: **McLaren Bay Region Sunrise Medical Clinic**

Telephone: **(989) 778-2400** Fax: **(989) 778-2402**

NUMBER OF PAGES: \_\_\_\_\_ [including cover sheet]

REMARKS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If your clinic is capable of sending and receiving electronic referrals through your EMR [Meaningful Use Requirement] please contact us so we can exchange direct message ID's.

***If this facsimile has reached you in error, please contact the above person immediately.  
Your assistance is appreciated. Thank you.***

**CONFIDENTIALITY NOTE**

**This information** may have been disclosed to you from records whose confidentiality is protected by federal and state laws. Federal regulations including [42 CFR, Parts 160 and 164] and state laws [Public Act 258, Chapter 7, Section 748] prohibit you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

**If the reader** of this information is not the intended recipient, you are hereby notified that any use, disclosure, dissemination, distribution, or reproduction of this information is strictly prohibited. If you have received this information in error, please immediately notify us by telephone and return the original to us at the address listed above via the **United States Postal Service**. Thank you.