McLaren
MEDICAL GROUP

RE: _____ Other names: _____
Patient Name

Date of Birth: _____ Dates of service: _____

Your request was received by our facility _____. We need to inform you that your request cannot be processed for the following reason(s) checked:

_____ We can find no record on the above named patient. If you can provide further information, we will make another file search.

_____ Patient was not at this facility during the time period indicated in your request.

_____ The enclosed AUTHORIZATION TO RELEASE MEDICAL INFORMATION must be properly completed to release information.

_____ Authorization was not signed and/or dated.

_____ Authorization was not signed by the patient. If the patient is unable to sign, an "X" witnessed by two persons will suffice.

_____ Authorization does not name our facility as authorized to release, and/or it does not indicate to whom records are to be released.

_____ We have no signature comparison and/or there is a discrepancy in the signature compared to our records and therefore we require a Notarized authorization.

_____ Patient is a minor. An authorization signed by the responsible parent or legal guardian is required.

_____ We require a copy of guardianship/custody/Power of Attorney/letter of authority papers prior to processing your request.

_____ Authorization is invalid since it was signed over 2 months ago.

_____ Authorization is invalid since it was dated prior to treatment.

_____ Authorization is invalid since the signature on the authorization is a copy with other information filled-in as an original. Authorizations should be properly completed at the time the patient signs.

_____ Other: _____

_____

_____

Upon receipt of the above, we will promptly respond to your request.

Respectfully,

Facility _____

Address _____

Telephone _____