

Business Products

McLaren Print System Order

Order No: 67835 Reprint Previous Order No: 26288

Order Date: 2022-02-21 **User: TINA PLAUTZ** Phone: 248-674-2259

Ship Location: Mclaren Oakland Waterford Medical Associates

5210 Highland Rd Ste 201

Waterford, MI 48327

Forms

Quantity: 500

Paragon Dept No: 73000

Dept Name: Waterford Medical Associates

Company Number: 810

Order Total Price: 0.00

Item Number: MM-336

Item Description: Authorization to Release Information to Family/Friend

Revision Date: 3/2019

Print: 1 sided black and white

Paper: 20# White Text

Size: 8.5 x 11 Fold:

Finish: None **Drill: None** Misc Info:



HEALTH CARE

Authorization for Verbal Release of Information to Family Members and Friend
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By signing this form, I am authorizing my health care provides to be involved in **settled** discussions regarding my health care with the family members or friends blood below. This may include test results, diagnoses, treatment spitchs, and other information from provious solds or treatment.

NAME OF TAMICUTRIENS	PHONE NUMBER	RELATIONSHIP (FAMILITYTHENE)	
	-		

The following information has special protection under Michigan law and will be made available to the people for listed elever only if i indicate my approval by initialing the lines below:

—HN/MOS or after communicable diseases including sexually transmitted diseases, venereal diseases, toleroclassis and topositios.

NOTE: This form does NOT give the people listed above the right to assess or receive a copy of my medical resords or medical information. It is not a consent for treatment, it is not to be used to request restrictions on the sharing of my information.

I understand that I can revoke or cancel this form at any time is writing. This form does not require unless revoked. I understand that are disclosure to an individual made from this authorization carries with it the potential for that individual is there the information and that since a disclosure is made reliable understand produced by individual and state confidentially laws. I understand that my treatment, payment, enrufitment or eligibility for brenefits is not conditioned on my signing this authorization.

Signature	of Pytient	n Patient	i Legal	Representati	we
Printed	Norme of A	ydianet's L	ngod Res	prosentative	