

Business Products

McLaren Print System Order

Order No: 70220 Reprint Previous Order No: 26288

Order Date: 2022-06-03 User: nicole jones Phone: 8106644531

Ship Location: Mclaren Lapeer Medical Office Building

1200 Barry Drive lapeer, MI 48446

Forms

Quantity: 1000

Paragon Dept No: 50504

Dept Name: Mclaren Lapeer Medical Office Building

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 melease of	Information to Fa	mny Mem	ibers and trie	na

Date of Birth 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 SAMICS/TRENO	PHONE NUMBER	RELATIONSHIP (FAMILY/TRENE)

The following information has special protection under Michigan law and will be made available to the people five land-above only if indicate my approval by initialing the lines below:

_______MN/MDE or other communicable diseases including sexually transmitted diseases, venereal diseases, toleroclaims and hopotitis.

NOTE: This form does NOT give the people listed above the right to access or receive a copy of my medical records or medical information, it is not a comment for treatment, it is not to be used to request restrictions on

I understand that I can revoke or cancel this form at any time in 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 to their the information and that once a disclosure in made reliable understand that their and once the individual to their thin authorization it is no longer protected by federal and state confidentially line. I understand that my treatment, payment, enrutiment or eligibility for brenefits is not conditioned on my signing this authorization.

Signature of Patient or Patient's Legal Representative

Printed Name of Patient's Legal Representative