

**McLaren Print System Order**

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Ship Location: MMG Davison Community Medical Center  
10090 E. Lippincott Blvd  
Davison, Michigan 48423

**Forms**

Quantity: 50  
Paragon Dept No: 50002  
Dept Name: MMG Davison CMC  
Company Number: 10

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Item Number: MHC\_RI\_0001.7.4  
Item Description: Waiver of Right to Free Interpreter Services  
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**Waiver of Right to Free Interpreter Services for Foreign Language and Hearing-Impaired Persons**

McLaren Health Care ("MHC") is committed to ensuring that all patients have equal and meaningful access to medical treatment and provides free interpreter services to assist all patients in effective communication.

I understand that MHC offers language interpretation services for the hearing impaired and/or non-English and/or limited English-speaking patients to me and my family at no cost. Services include qualified professional medical interpreters available by telephone, video or a through a qualified in-person interpreter.

I acknowledge that I am refusing these free interpreter services and have chosen to use my own interpreter, at my own expense, for personal reasons. (Name of person/company serving as interpreter) \_\_\_\_\_ will act as my interpreter for this visit/hospitalization. To my knowledge, my interpreter is over the age of 18 and understands medical information.

Even though I am providing my own interpreter, MHC may also elect to use an interpreter of its choosing to assist physicians and staff to communicate with me during this visit/hospitalization to ensure accuracy of the interpretation being provided.

I understand that any interpreter I choose to use will have access to any of my confidential medical information being discussed. All MHC-provided interpreters are obligated to maintain the confidentiality of all information discussed.

**Spec Info:** I understand that I may withdraw this Waiver at any time and request the services of a qualified interpreter provided free of charge by MHC.

This waiver has been translated to me by through a qualified interpreter.

Patient Name & Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

MHC Staff Name & Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Interpreter Name & ID #: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_