

## **Business Products**

## McLaren Print System Order

Order No: 73597 Reprint Previous Order No: 26288

Order Date: 2022-11-11 User: nicole jones Phone: 8106674142

Ship Location: Mclaren Metamora community medical center

809 W Dryden Road Metamora, Michigan 48455

**Forms** 

Quantity: 1000

Paragon Dept No: 50509

**Dept Name: Mclaren Metamora Community Medical Center** 

**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 Frien	١d
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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 TAMILITY THEND	PHONE NUMBER	RELATIONSHIP (FAMILY/TRENE)

The following information has special protection under Michigan law and will be made available to the people for listed elever only if i indicate may approved 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 records 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 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.

ignature of hyde	ent or Patient's	Legal Represe	entutive
Printed Name	of framework to	ad Bassanasta	-