

Business Products

McLaren Print System Order

Order No: 74500 Reprint Previous Order No: 26288

Order Date: 2023-01-09 **User: Dorothy Craig** Phone: 5176474166

Ship Location: McLaren MMP Portland Family Care

406 Kent St. Portland, MI 48875

Forms

Quantity: 500

Paragon Dept No: 68375

Dept Name: MGL MMP Portland Family Care

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 Inf	formation to Family	Members :	and Friends

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/TREND	PHONE NUMBER	RELATIONSHIP (FAMIL/LUTRENE)

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 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.

Signature of	hydient or Patient's Legal Representative
Printed No	me of Patient's Legal Representative