

## **Business Products**

## McLaren Print System Order

Order No: 77246 Reprint Previous Order No: 26288

Order Date: 2023-05-12 **User: Danielle Cahoon** Phone: 810-688-3093

Ship Location: Mclaren Family Care Center/Danielle Cahoon

4482 Huron Street North Branch, MI 48461

**Forms** Quantity: 500

Paragon Dept No: 65250

Dept Name: Mclaren Family Care Center-North Branch

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 Friends	Authorization for	Verbal Release of	Information to Family	Members and Friends
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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 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 less. 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 Logal Representative