McLaren Business Products

**McLaren Print System Order**

**Order No: 77344 Reprint Previous Order No: 26288**
**Order Date: 2023-05-17**
**User: Danielle Cahoon**
**Phone: 810-346-2757**

**Ship Location: Mclaren Brown City Health Care Center /Danielle Cahoon**
**7115 Cade Rd**
**Brown City, MI 48416**
**Forms**
**Quantity: 500**
**Paragon Dept No: 65400**
**Dept Name: Mclaren Brown City Health Care 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:**

McLaren
HEALTH CARE

**Authorization for *Verbal* Release of Information to Family Members and Friends**

Patient Name _____ Date of Birth _____

By signing this form, I am authorizing my health care providers to be involved in **verbal** discussions regarding my health care with the family members or friends listed below. This may include test results, diagnoses, treatment options and other information from previous visits or treatment.

| NAME OF FAMILY/FRIEND | PHONE NUMBER | RELATIONSHIP (FAMILY/FRIEND) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

The following information has special protection under Michigan law and will be made available to the people I've listed above only if I indicate my approval by initialing the lines below:
_____ HIV/AIDS or other communicable diseases including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis
_____ Substance abuse services
_____ Mental health services

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 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 expire unless revoked. I understand that any disclosure to an individual made from this authorization carries with it the potential for that individual to share the information and that once a disclosure is made under this authorization it is no longer protected by federal and state confidentiality laws. I understand that my treatment, payment, enrollment or eligibility for benefits is not conditioned on my signing this authorization.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Printed Name of Patient's Legal Representative

File in Patient's Medical Record