# McLAREN CENTRAL MICHIGAN

1221 SOUTH DRIVE, MT. PLEASANT, MI 48858

# **Authorization to Release Information**

Patient Name			Birthdate		Medical Record Number	
Address						
Phone Number			Maiden/Other Nar	nes		
l authorize			to release to			
	(name)			(name)		
				(address)		
	(address)			(city, state, zip)		
	(city, state, zip)			(telephone/fax)	one/fax)	
	(telephone/fax)			(email address)		
☐ Cons ☐ Labo ☐ Diagi ☐ Diagi	nostic Imaging (e.g.	☐ Operative Report ☐ Therapy Notes ☐ Billing Records ., X-Rays) reports from ., X-Rays) films from (d	☐ Discharge Sur ☐ Home Care Ro (date) ate)	mmary ecords		
Sensitive	information to	o be disclosed:		Date(s)	of Service:	
□ Beha	avioral and Mental F	Health Service Informat	ion (excluding Psych	otherapy Notes)		
		for alcohol and substa				
		s such as sexually trans			eficiency virus	
(miv ini	ection, Acquired Im	mune Deficiency Synd	TOTHE OF AIDS RELATE	u Complex)		
□ Conser	nt to release <u>E</u>	ntire Medical Rec	ord, for dates o	f service liste	d, including all information noted a	
Date(s) of	Service:		-			
				Initials	Date	

Please continue to the other side of this form for Acknowledgements and signatures.



## McLAREN CENTRAL MICHIGAN

1221 SOUTH DRIVE, MT. PLEASANT, MI 48858

### Authorization to Release Information

### By signing this form I understand:

- 1. That I do not need to sign this form in order to ensure treatment, payment for treatment or enrollment or eligibility for health benefits.
- 2. My health information may be shared electronically.
- 3. The sharing of my health information will follow state and federal laws and regulations.
- 4. This form does not give my consent to share psychotherapy notes as defined by federal law.
- 5. I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more than 60 days after date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's information is permitted.
- 6. I should tell all agencies and people listed on this form when I withdraw my consent.
- 7. I can have a copy of this form.
- 8. That unless otherwise indicated or specified here, a request for disclosure or release of my "Entire Medical Record" or health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
- That any disclosure of information carries with it the potential for redisclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.
- 10. I understand that if I request for McLaren to email me a copy of my medical record, it may not be possible due to mailbox size and/or security restrictions. I also understand that if McLaren is able to send my record to my email, McLaren will apply reasonable safeguards but cannot guarantee the security of your record when sending it to an unsecured personal email account.
- 10. By signing this form, I confirm that I understand the information and any questions have been answered about this form.

Signature of Patient or Legal Representative	Date	
If Signed by Legal Representative, State Relationship to Patient		_
Signature of Witness	Date	