

Business Products

McLaren Print System Order

Order No: 79366 Reprint Previous Order No: 26288

Order Date: 2023-09-13 **User: STEPHANIE BENDER**

Phone: 2314877200

Ship Location: McLaren Gaylord Family Practice

1320 M-32 East Gaylord, MI 49735

Forms

Quantity: 1000

Paragon Dept No: 50684

Dept Name: McLaren Gaylord Family Practice

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

Nuthorization for	Perbal Release of	Intermation to I	ramny Mem	bers and Friends

Date of Birth 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 access or neceive 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

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 Pytient	or Patient	's Legal	Representati	ive
Printed	Name of	Pytheret's Li	ngal Re	promentative	