

**McLaren Print System Order**

**Order No: 84807 Reprint Previous Order No: 26288**  
**Order Date: 2024-04-23**  
**User: Leah Blair**  
**Phone: 9898263271**

**Ship Location: Primary Care Att Beth**  
**2990 Campbell Rd**  
**Rose City , Michigan 48654**

**Forms**

**Quantity: 100**  
**Paragon Dept No: 69230**  
**Dept Name: Primary Care**  
**Company Number: 810**

**Order Total Price: 3.35**

**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:**

**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, diagnosis, 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