McLaren Business Products

McLaren Print System Order

Order No: 89761
Order Date: 2024-11-11
Order Request Date:
User: Angie Claerhout
Phone: 9896672802

Ship Location: Bay Spine Surgery
4175 N Euclid Ave Suite 9
Bay City, Michigan 48706
Brochures
Quantity: 100
Paragon Dept No: 56087
Dept Name: McLaren Bay Spine Surgery
Company Number:

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
Poster:
Misc Info:

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

Spec Info: WestSide Medical Mall -Attn: Angie Claerhout -Suite #9