McLaren Business Products

McLaren Print System Order

Order No: 89769
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: 17418
Item Description: Authorization to Release Information (this is a corporate wide form c/o Medical Records)
Revision Date: 5/2013
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Poster:
Misc Info:


McLaren Health Care Corporation

Authorization to Release Information

Patient Name | Birth Date | Medical Record Number

Address

Telephone Number | Maiden/Other Names

I authorize (name) (address) (city, state, zip) (telephone/fax)

to release to (name) (address) (city, state, zip) (telephone/fax) (email address)

Specific type of information to be disclosed: Date(s) of Service

- History and Physical
- Operative Report
- Discharge Summary
- Physician's Notes
- Consultation Reports
- Therapy Notes
- Home Care Records
- Entire Medical Record
- Laboratory Results
- Billing Records
- Diagnostic Imaging (e.g. X-Rays) reports from (date)
- Diagnostic Imaging (e.g. X-Rays) films/CD from (date)
- Other

The purpose and need for disclosure:

- Continuation of Care
- Personal
- Insurance Billing
- Legal/Attorney
- Prefer not to answer
- Other

I understand that unless otherwise indicated or specified here, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug and/or alcohol 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).

I understand that any disclosure of information carries with it the potential for re-disclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

I understand that I have a right to revoke this authorization at any time by sending a written revocation to the organization's HIPAA/Privacy Officer. 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 90 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.

I understand that I need not sign this form in order to ensure treatment, payment for treatment, or enrollment or eligibility for health benefits.

Signature of Patient or Legal Representative | Date

If Signed by Legal Representative, State Relationship to Patient

Signature of Witness | Date

AUTHORIZATION TO RELEASE HEALTH INFORMATION

8400

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