McLaren Business Products

**McLaren Print System Order**

**Order No: 90837**
**Order Date: 2024-12-13**
**Order Request Date:**
**User: Tonya Furtah**
**Phone: 8105618450**

**Ship Location: MMG-St. Clair Family Practice - Attn: Tonya**
**1163 St. Carney Drive**
**St. Clair, MI 48079**
**Brochures**
**Quantity: 500**
**Paragon Dept No: 54000-1250**
**Dept Name: MMG-St. Clair Family Practice**
**Company Number:**

**Order Total Price: 16.75**

**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:**

McLaren
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: Original Poster Size**