

**McLaren Print System Order**

**Order No: 48695 Reprint Previous Order No: 6293**  
**Order Date: 2019-09-18**  
**User: Theda Simmonds**  
**Phone: 989-393-2857**

**Ship Location: McLaren Occupational and Convenient Care - Bay City**  
**4 Columbus Ave**  
**Bay City, MI. 48708,**

**Forms**

**Quantity: 1000**  
**Paragon Dept No: 69100**  
**Dept Name: Occupational Convenient Care**  
**Company Number: 810**

**Order Total Price: 0.00**

**Item Number: 17418**  
**Item Description: Authorization to Release Information (this is a corporate wide form c/o Medical Records)**  
**Revision Date: 4/28/2015**  
**Print: 2 sided black and white**  
**Paper: 20# White Text**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish:**  
**Drill: None**  
**Misc Info:**

**McLAREN HEALTHCARE**  
**Authorization to Release Information**

Patient Name \_\_\_\_\_ Ethnicity \_\_\_\_\_ Medical Record Number \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ Identification Number \_\_\_\_\_

I authorize \_\_\_\_\_ to release to \_\_\_\_\_  
(Name) (Name)  
\_\_\_\_\_ (Address)  
\_\_\_\_\_ (Address)  
City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
County/Zip \_\_\_\_\_ County/Zip \_\_\_\_\_  
Telephone/Fax \_\_\_\_\_ Email Address \_\_\_\_\_

**Specific type of information to be disclosed:** \_\_\_\_\_ **Date(s) of Service:** \_\_\_\_\_  
 History and Physical  Operative Report  Physician's Notes  
 Consultation Reports  Therapy Notes  Discharge Summary  
 Laboratory Results  Billing Records  Home Care Records  
 Diagnostic Imaging (e.g., X-Ray reports from (date) \_\_\_\_\_  
 Diagnostic Imaging (e.g., X-Ray) films from (date) \_\_\_\_\_  
 Other \_\_\_\_\_

**Sensitive information to be disclosed:** \_\_\_\_\_ **Date(s) of Service:** \_\_\_\_\_  
 Behavioral and Mental Health Service Information (including Psychotherapy Notes)  
 Substance abuse treatment for alcohol and substance use disorder  
 Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS-Related Complex)

Consent to release **Entire Medical Record**, for dates of service listed, including all information noted above:  
**Date(s) of Service:** \_\_\_\_\_ **Initials** \_\_\_\_\_ **Date** \_\_\_\_\_

Please continue to the other side of this form for Acknowledgements and signatures.