

## McLaren Print System Order

Order No: 49201 Reprint Previous Order No: 26288  
 Order Date: 2019-10-03  
 User: Danielle Cahoon  
 Phone: 810-688-3093

Ship Location: McLaren Family Care Center/Danielle Cahoon  
 4482 Huron Street  
 North Branch, MI 48461

### Forms

Quantity: 1000  
 Paragon Dept No: 65250  
 Dept Name: McLaren Family Care Center-North Branch  
 Company Number: 810

Order Total Price: 0.00

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