

**McLaren Print System Order**

**Order No: 57648 Reprint Previous Order No: 6293**  
**Order Date: 2020-10-15**  
**User: Chelsey Johnson**  
**Phone: 517-913-3820**

**Ship Location: ATTN: Chelsey (Operations Supervisor)**  
**1540 Lake Lansing Road STE 202**  
**Lansing, MI 48912**

**Forms**

**Quantity: 1000**  
**Paragon Dept No: 68025**  
**Dept Name: McLaren Family Medicine & Lipidology**  
**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 \_\_\_\_\_ Insurance/Other Payers \_\_\_\_\_

I authorize \_\_\_\_\_ to release to \_\_\_\_\_  
(Name) (Name)  
\_\_\_\_\_ (Address) \_\_\_\_\_ (Address)  
\_\_\_\_\_ (City, State, Zip) \_\_\_\_\_ (City, State, Zip)  
\_\_\_\_\_ (Telephone/Fax) \_\_\_\_\_ (Telephone/Fax)  
\_\_\_\_\_ (Email Address) \_\_\_\_\_ (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 other) \_\_\_\_\_  
 Diagnostic Imaging (e.g., X-Ray reports from other) \_\_\_\_\_  
 Other \_\_\_\_\_

**Sensitive information to be disclosed:** Date(s) of Service: \_\_\_\_\_  
 Behavioral and Mental Health Service Information (including Psychotherapy Notes)  
 Substance abuse/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.