

**McLaren Print System Order**

**Order No: 58925 Reprint Previous Order No: 6293**  
**Order Date: 2020-12-10**  
**User: MICHELLE GALATI**  
**Phone: 5867254604**

**Ship Location: McLaren Womens Health Chesterfield**  
**51086 Fairchild Rd**  
**Chesterfield, Michigan 48051**

**Forms**

**Quantity: 100**  
**Paragon Dept No: 72000**  
**Dept Name: McLaren Womens Health Chesterfield**  
**Company Number: 260**

**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)  
(Home/Work) (Home/Work)

**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 reports 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 (AIDS), and/or Cryptococcal meningitis

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.