McLaren Business Products

McLaren Print System Order

Order No: 59636 Reprint Previous Order No: 26288
Order Date: 2021-01-13
User: Kimberly Smirnes
Phone: 586-466-4810

Ship Location: McLaren Macomb Heart Rhythm Treatment Center
21550 Harrington Blvd., Suite C
Clinton Township, MI 48036
Forms
Quantity: 100
Paragon Dept No: 72400
Dept Name: McLaren Macomb Heart Rhythm Treatment Center
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:

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