McLaren Business Products

McLaren Print System Order

Order No: 59705 Reprint Previous Order No: 6293
Order Date: 2021-01-16
User: VICKI YAROCH
Phone: 989-269-9521

Ship Location: MCLAREN THUMB REGION
1100 S VAN DYKE
BAD AXE, MI 48413
Forms
Quantity: 1000
Paragon Dept No: 2210
Dept Name: CENTRAL REGISTRATION
Company Number: 530

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 | Birthdate | Medical Record Number

Address

Phone Number | Maiden/Other Names

I authorize _____ (name) to release to _____ (name)

(address) | (address)

(City, State, Zip) | (City, State, Zip)

(telephone/fax) | (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-Rays) reports from (date) _____
☐ Diagnostic Imaging (e.g., X-Rays) films from (date) _____
☐ Other_____

Sensitive information to be disclosed: Date(s) of Service: _____

☐ Behavioral and Mental Health Service Information (excluding Psychotherapy Notes)
☐ Rehab and 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 otherside of this form for Acknowledgements and signatures.

AUTHORIZATION TO RELEASE INFORMATION
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