

McLaren Print System Order

Order No: 6215
Order Date: 2014-10-02
User: Kelly Lewis
Phone: 810-496-0916

Ship Location: Grand Blanc Occupational -- Kelly Lewis
2313 E. Hill Rd.
Grand Blanc, MI 48439

Forms
Quantity: 2500
Paragon Dept No: 64100
Dept Name: Burton Occupational
Company Number: 810

Order Total Price: 81.75

Form Number: MM-34216
Form Description: Authorization to Release Information
Revision Date: 12/4/2013
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: 5 Hole Top

McLaren Medical Group
Authorization to Release Information

Patient Name: _____ ID# _____ Medical Record Number: _____
 Address: _____
 City/State/Zip: _____

Physician Name: _____
 Department Name: _____

I authorize _____ to release to _____
 (Name) (Name)
 Address: _____ Address: _____
 City/State/Zip: _____ City/State/Zip: _____
 Telephone/Fax: _____ Telephone/Fax: _____
 Email address: _____

Specify type of information to be disclosed: Select all that apply.
 History and Physical Operative Report Discharge Summary Physician's Notes
 Consultation Reports Therapy Notes Home Care Records Extra Medical Records
 Laboratory Results Billing Records
 Diagnostic Imaging (e.g., X-Rays, reports from CAT, MRI)
 Other _____

The purpose and need for disclosure:
 Continuation of Care Personal Insurance Billing
 Legal/Forensic Provider to another Other _____

I understand that unless otherwise indicated or specified here, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding various communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

I understand that any disclosure of information carries with it the potential for redisclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

I understand that I have a right to revoke this authorization at any time by sending a written revocation to the organization's HIPAA Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more than 90 days after date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's information is permitted.

I understand that I need not sign this form in order to ensure treatment, payment for treatment, or enrollment or eligibility for health benefits.

Signature of Patient or Legal Representative: _____ Date: _____
 I Signed by Legal Representative, Sole Beneficiary to Patient
 Signature of Releasee: _____ Date: _____

Revised 12/4/2013
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