

McLaren Print System Order

Order No: 6517
Order Date: 2014-10-16
User: Angela DeLaRosa
Phone: 3720 Katalin Ct, Suite 201 (989) 893-9705

Ship Location: McLaren Bay Region Family Medicine/Attn Angela DeLaRosa
3720 Katalin Ct
Bay City, MI 48706

Forms
Quantity: 100
Paragon Dept No: 60841
Dept Name: McLaren Medical Group
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:
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren Health Care Corporation
Authorization to Release Information

Patient Name _____ Date of Birth _____ Medical Record Number _____
Address _____
Telephone Number _____ Patient/Other Name _____

I authorize _____ to release to _____
Address _____
City, State, Zip _____
City, State, Zip _____
Address _____
City, State, Zip _____
Address _____
City, State, Zip _____
Address _____
City, State, Zip _____

Specific type of information to be disclosed: History and Physical Operative Report Discharge Summary Physical Notes
 Consultation Reports Therapy Notes Home Care Records Extra Medical Records
 Laboratory Results Billing Records
 Diagnostic Imaging (X-Ray/Barium/CT Scan, etc.)
 Other _____

The purpose and need for disclosure: Continuation of Care Personal Insurance Billing
 Legal/Forensic Public Health Interest 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 and/or alcohol treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes genital disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

I understand that any disclosure of information carries with it the potential for re-disclosure 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 Information Officer. I understand that this 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 _____
Signature of Patient Representative, Not Authorized to Sign _____
Signature of Releasee _____ Date _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION
FORM HL 00000000



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