

McLaren Print System Order

Order No: 7055
 Order Date: 2014-11-11
 User: Pamela Dietrich
 Phone: 810 953 6400

Ship Location:
 2313 East Hill Road
 Grand Blanc, MI 48439

Forms
 Quantity: 500
 Paragon Dept No: 64050
 Dept Name: 64050
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-34216
 Item 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: None
 Misc Info:

McLaren Medical Group
Authorization to Release Information

Patient Name: _____ Address: _____ Date of Birth: _____

 Physician Name: _____ Physician Office: _____

I authorize _____ to release to _____

(Name) _____ (Name) _____
 (Address) _____ (Address) _____
 (City/State/Zip) _____ (City/State/Zip) _____
 (Telephone) _____ (Telephone) _____
 (E-mail address) _____ (E-mail address) _____

Specify type of information to be disclosed: Date of Service:

History and Physical Operative Report Discharge Summary Physician Notes
 Consultation Reports Therapy Notes Home Care Records Entry Medical Record
 Laboratory Results Billing Records
 Diagnostic Imaging (i.e., X-Ray) reports from (date) _____
 Diagnostic Imaging (i.e., X-Ray) film from (date) _____
 Other _____

The purpose and need for disclosure:

Continuation of Care Personal Insurance Billing
 Legal/Compliance Public Not to Answer 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 services 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 60 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, Date Expiration to Patient: _____

 Signature of Witness: _____ Date: _____

Revised 12/4/2013
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