

McLaren Print System Order

Order No: 8192
Order Date: 2015-01-13
User: Diana Garver
Phone: 989-644-3329

Ship Location: Weidman/Andrea
3520 North Woodruff Road
Weidman, MI 48893

Forms
Quantity: 500
Paragon Dept No: 75225
Dept Name: Weidman Clinic
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: 5/2013
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, Maiden/Other Names, I authorize, To Release to, Specific type of information to be disclosed, Category of Service, The purpose and need for disclosure, 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.