

**McLaren Print System Order**

**Order No: 8905**  
**Order Date: 2015-02-10**  
**User: Torey Locsin**  
**Phone: 248-808-5850**

**Ship Location: Front Desk**  
**3901 Highland Rd., Suite D**  
**Waterford, MI 48328**

**Forms**  
**Quantity: 100**  
**Paragon Dept No: 73650**  
**Dept Name: McLaren Oakland Waterford Family Med**  
**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 \_\_\_\_\_ Patient/Other Name \_\_\_\_\_

I authorize \_\_\_\_\_ to release to \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
County/City \_\_\_\_\_  
State/Zip \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
County/City \_\_\_\_\_  
State/Zip \_\_\_\_\_  
Email address \_\_\_\_\_

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 or Safety  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 Legal Representative, Not Authorized by Patient \_\_\_\_\_  
Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**  
FORM HL 01000000



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