McLaren
HEALTH CARE

AUTHORIZATION TO RELEASE INFORMATION

Patient Name _____ Birthdate _____ Medical Record Number _____

Address _____

Phone Number _____ Maiden / Other Names _____

I authorize _____ (name)
_____ (address)
_____ (city, state, zip)
_____ (telephone / fax)

to release to _____ (name)
_____ (address)
_____ (city, state, zip)
_____ (telephone / fax)
_____ (email address)

Specific type of information to be disclosed: **Date(s) of Service** _____

- ☐ History and Physical ☐ Operative Report ☐ Physician's Notes
- ☐ Consultation Reports ☐ Therapy Notes ☐ Discharge Summary
- ☐ Laboratory Results ☐ Billing Records ☐ Home Care Records
- ☐ Diagnostic Imaging (e.g., X-Rays) reports from (date) _____
- ☐ Diagnostic Imaging (e.g., X-Rays) films from (date) _____
- ☐ Other _____

Sensitive information to be disclosed: **Date(s) of Service** _____

- ☐ Behavioral and Mental Health Service Information (excluding Psychotherapy Notes)
- ☐ Referrals and treatment for alcohol and substance use disorder
- ☐ Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

☐ **Consent to release <u>Entire Medical Record</u>, for dates of service listed, including all information noted above:**

Date(s) of Service _____ _____
Initials **Date**

Purpose of disclosure (Ohio residents only): _____

Please continue to the other side of this form for Acknowledgments and signatures.

840

PT.

MR.#/RM

DR.

McLaren
HEALTH CARE

AUTHORIZATION TO RELEASE INFORMATION

By signing this form I understand:

1. That I do not need to sign this form in order to ensure treatment, payment for treatment or enrollment or eligibility for health benefits.
2. My health information may be shared electronically.
3. The sharing of my health information will follow state and federal laws and regulations.
4. This form does not give my consent to share psychotherapy notes as defined by federal law.
5. I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back. 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.
6. I should tell all agencies and people listed on this form when I withdraw my consent.
7. I can have a copy of this form.
8. That unless otherwise indicated or specified here, a request for disclosure or release of my "Entire Medical Record" 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 serious communicable diseases and infections as defined by the Michigan Department of Public Health Code and / or the Ohio Administrative Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
9. 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.
10. I understand that if I request for McLaren to email me a copy of my medical record, it may not be possible due to mailbox size and / or security restrictions. I also understand that if McLaren is able to send my record to my email, McLaren will apply reasonable safeguards but cannot guarantee the security of your record when sending it to an unsecured personal email account and I accept the risk.
11. By signing this form, I confirm that I understand the information and any questions have been answered about this form.

Signature of Patient or Legal Representative _____ Date _____

If Signed by Legal Representative, State Relationship to Patient _____

Signature of Witness _____ Date _____

PT.

MR.#/RM

DR.