Job #

Reset

**McLaren Regional Medical Center**
FLINT, MICHIGAN 48532

## AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____ Soc. Security # _____

Patient address _____
Street City State Zip

Patient phone number _____ Maiden/Other Name _____

I authorize McLaren Medical Center – Flint to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services). PLEASE CROSS OFF ANY THAT SHOULD NOT BE RELEASED.

1. Name and address to whom the information may be released.
   Legal Copy Services, Inc. 3280 N. Evergreen Drive N.E. Grand Rapids, MI 49525

2. Specific Information to be disclosed; including types of information and dates of service.

3. The purpose and need for such disclosure:
   Civil Litigation

   (For mental health records, or records pertaining to HIV infection or AIDS, the above paragraph must include a statement as to how the information to be disclosed is germane to the purpose and need for such disclosure.)

4. Expiration date or 60 days from the date of this signed authorization: _____

If you sign this authorization, you can revoke it later. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation of the authorization unless as otherwise allowed by law.

If you sign this authorization, your are authorizing MRMC to release the protected health information not created by MRMC and that MRMC cannot verify the accuracy or completeness of records created by other providers.

If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to:

Medical Record Department
McLaren Regional Medical Center
401 S. Ballenger Highway
Flint, MI 48532

Your health information will be disclosed as provided in this authorization. The information may be subject to re-disclosure by the recipient and may no longer be protected.

**I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.**
**I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.**

5. Dated _____ Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship and the source of your authority to sign this form.

Relationship to Patient _____ Print Name _____

Witness _____

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**
M-17418 (5/08)


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PT.

MR.#/RM.