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 Names_____

I authorize MCLAREN REGIONAL MEDICAL CENETR 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:

RECORDS DEPOSITION SERVICE
P.O. BOX 5054, SOUTHFIELD, MI 48086-5054
PHONE: (248) 357-3330

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

3. The purpose and need for such disclosure:

DISCOVERY.

(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 Event: 6 MONTHS FROM THE DATE OF SIGNING.

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 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 to the patient and the source of your authority to sign this form

Relationship to Patient_____ Print Name_____

Source of Authority_____

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MR.#/RM