LAKESHORE AREA RADIATION ONCOLOGY CENTER

Authorization PEOPLE INVOLVED IN PATIENT'S CARE - LAROC

Patient Name

DOB

MRN

Physician

CSN

I have the right to choose family members, friends or others to be involved in talks about my health care. The people listed below may receive any verbal information needed to be involved in my care or to help me make decisions about my care. By signing this form, I give my permission for staff within Corewell Health to discuss information about me with the people listed. The information discussed may include diagnosis, test results, medicine, treatment options and other information from previous services I have had, either in hospitals or other locations.

- I know that information may be discussed with family members or others without this form, if allowed by federal and state laws.*
- I know that listing a person on this form does not allow them to get or copy my medical records.
- People listed on this form are not allowed to give consent for services for me.**
- For a minor, parents are assumed to be designated except for those services which the minor has given consent under Michigan law.

LIST PEOPLE THAT MAY PICK UP PRESCRIPTIONS/MEDICINES AND RECEIVE VERBAL INFORMATION ABOUT YOUR CARE

NAME OF PERSON	RELATIONSHIP	CONTACT PHONE NUMBER(S)	DO NOT ALLOW PERSON TO RECEIVE VERBAL INFORMATION ABOUT YOUR CARE	DO NOT ALLOW PERSON TO PICK UP ALL PRESCRIPTIONS
			☐	☐
			☐	☐
			☐	☐
			☐	☐

_____ ☐ I do NOT wish to name anyone. (if box is checked, initial)

The following information has special protection under Michigan law and will be made available to the people listed above ONLY IF I give my approval by checking the box(es) below AND initial the line(s).

_____ ☐ HIV/AIDS or other diseases – tuberculosis, hepatitis, venereal diseases, sexually transmitted diseases

_____ ☐ Substance abuse services

_____ ☐ Mental health services

I can update this form at any time by telling a Corewell Health staff member AND by filling out a new form. I can take away my permission to share my information at any time by putting that request in writing and giving that request to a Corewell Health staff member. This form is valid for one (1) year from date of signature.

PATIENT SIGNATURE(S)

I have read this form and I understand it. All my questions have been answered.

TIME _____ ☐ AM/☐ PM **DATE** _____ Patient signature _____

☐ Patient is under 18 years of age or otherwise unable to consent because _____

_____

TIME _____ ☐ AM/☐ PM **DATE** _____

Parent/Legal Guardian/Patient Advocate/Next of Kin signature _____

*Refer to Corewell Health Hospital Notice of Privacy Practices.

**Other forms are required for these purposes.

DO NOT MARK BELOW THIS LINE — BARCODE ZONE — DO NOT MARK BELOW THIS LINE

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