Marquette University Medical Clinic
Division of Student Affairs
Schroeder Complex Lower Level
P.O. Box 1881 Milwaukee, WI 53201
Phone: (414) 288-7184 Fax: (414) 288-1664

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Information

Name:		
Address:		
City:	State:	Zip Code:
Birthdate:	MU ID#	Phone:

Records to be release from:

_____
Name (i.e. Heath Facility Physician)

_____
Address:

_____
City: State: Zip Code:

_____
Phone : Fax:

Records to be release to:

_____
Name (i.e. Lawyer, Physician, Self)

_____
Address:

_____
City: State: Zip Code:

_____
Phone : Fax:

Information to be released (Check **all** the apply)

☐ All Medical Records

☐ Vaccination/ TB records

☐ Clinic records pertaining to treatment of:_____

☐ Lab/X-ray reports during the period of _____ to _____
Date Date

☐ Other (Specify) _____

SENSITIVE INFORMATION
Marquette University Student Health Service works in compliance with Wisconsin State Statutes, which require special permission to release otherwise privileged information. Please see the reverse side for further information regarding the Wisconsin State Statute. Please release records pertaining to: (Please initial all applicable conditions)

___ AIDS/AIDS related illness ___ HIV test results
___ Developmental disabilities ___ Mental Health ___ Alcoholism/Drug Abuse

_____
Signature Date

Purpose or need for disclosure. Please initial **all** applicable categories

___ Insurance ___ Further medical care
___ Legal ___ Transferring Schools
___ Other _____

I authorize the release of my medical records in accordance with the specification listed above and acknowledge that I have read the reverse side. I recognize that I have the right to revoke this authorization by submitting the appropriate form available at Marquette University Student Heath Service. I understand that this disclosure is valid for **120** days after the date of signature. I understand that a new authorization is necessary for release of information on care provided after the date of signature. I understand that Marquette University Student Health Service is not responsible for re-disclosure of information after releasing to the requesting party.

_____ _____
Signature Date Signature of Person legally authorized to Give Consent

_____
Relationship to Patient

Marquette University Student Health Service reserves the right to make adjustments, and/or revisions to this form without prior notification.
Marquette University Student Health recognizes your ability to exercise your privacy rights under the authority of HIPAA without any retaliatory actions being used against you.
(Modified 8/2019)