Marquette University Medical Clinic
Wellness + Helfaer Recreation, WR200K
525 N. 16th Street Milwaukee, WI 53233
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

The Marquette University Medical Clinic 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 the Marquette University Medical Clinic. 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 the Marquette University Medical Clinic 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 Medical Clinic reserves the right to make adjustments, and/or revisions to this form without prior notification.
Marquette University Medical Clinic recognizes your ability to exercise your privacy rights under the authority of HIPAA without any retaliatory actions being used against you.
(Modified 5/2013