Releasing Medical Information

This form is used only to allow Marquette University Medical Clinic providers and staff members to release oral information with the written consent of the patient. This form only allows Marquette University Medical Clinic providers and staff to release oral information pertaining to one specific visit. This form will be valid for one year. A separate, completed authorization form is necessary to release paper copies of patient medical records.

I, _______________________________ _______________________________,

Please print name here                                      MU ID#

give my permission for Marquette University Medical Clinic providers and/or staff members to speak to:

________________________________________________________
Name of person to receive information

________________________________________________________
Relationship to patient

________________________________________________________
Phone number (if applicable)

About the following information regarding the date of service: _____________________________
Date of Service

☐ Date of visit only  ☐ Chronic Condition _____________________________

☐ Diagnosis  ☐ Treatment

☐ Follow-up Recommendations

☐ Specific information only (please specify in detail the information which may be released)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

______________________________________  ________________________________
Signature                                      Date