



Releasing Medical Information

Date _____

I, _____
Please print patient name _____
MU ID#

Give my permission for Marquette University Student Health Service Providers/Staff to speak to:

Name of person receiving information _____
Date

Relationship to patient _____
Date

Regarding:

Date(s) of treatment only _____
Date of Service

Date(s) of treatment and diagnosis _____
Date of Service

Specific information only (see below)

Specify in detail patient information to be released:

Signature of Patient

Date

(Please note: This form is used to allow SHS providers to release oral information with the written consent of the patient. A completed authorization form is necessary to release paper copies of patient health information).