Marquette University Student Health Service
Division of Student Affairs
Walter Schroeder Health and Science Complex
P.O. Box 1881 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#: __________

Records to be released from

Name (i.e. Health Facility Physician): ____________________

Address: ____________________

City: ____________________

State: __________ Zip Code: __________

Phone: __________ Fax: __________

Records to be released to

Name (i.e. Lawyer, Physician, Self): ____________________

Address: ____________________

City: ____________________

State: __________ Zip Code: __________

Phone: __________ Fax: __________

Information to be released (Check all applicable categories)

- ☐ All Medical Records
- ☐ Clinic records pertaining to treatment of: (Specify condition and approximate dates) ____________________
- ☐ Vaccination/Immunization records
- ☐ Lab/X-ray reports during the period of __________ (Date) to __________ (Date) (Circle one or both)
- ☐ 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 Statutes.

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 _____Absence from school or work
_____Other__________________ _____ Transferring Schools

Time Period Consent is Effective:

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 Health 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 the information 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, deletions, and/or revisions to this form without prior notification.
Marquette University Student Health Service recognizes your ability to exercise your privacy rights under the authority of HIPAA without any retaliatory actions being used against you.
(Modified 4/2002)

ADDITIONAL INFORMATION REGARDING RELEASE OF PATIENT MEDICAL RECORDS

Marquette University Student Health Services recognizes the patient's right to confidentiality of medical records as set forth in Wisconsin statutes. Therefore, the patient should be aware of the following guidelines when requesting medical records:

Wisconsin statutes recognizes the need for informed consent. The patient may request multiple releases of the information stated on the authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature. A *new authorization is necessary for release of information on care provided after the date of the patient's signature, unless it is stated in the authorization to release 'future records of a specific test, specifeed clinic appointment and/or admissions with the month and year identified."*

Generally, all patients 18 years of age and older must sign for release of their own records. Read the following to determine exceptions for patients older or younger then 18 years.

- All patients 18 years of age and over must sign for release of their own medical records unless the following conditions apply:

    a. The patient is incompetent.

    b. The patient is disabled and cannot sign the form

    c. The patient is deceased. (The legal representative must sign authorization releasing records of the deceased patient.)

- Patients under 18 years of age must sign for release of their medical records when:

    a. The patient is 14 years of age or older and the records involve treatment for mental illness, alcoholism, or drug dependence.

    b. The patient's records for release include abortion procedure(s).

- All persons other than the patient must state their relationship to the patient and have available proof of legal authority to sign for release of records.

Legal Authority:

O Guardian O Legal Representative of Deceased
O Parent of Minor O Health Care Power of Attorney

Patient is:

O Minor O Disabled
O Incompetent O Deceased