



# Medical Withdrawal - Healthcare Provider Release Information

Purpose: Used as an attachment to the Medical Withdrawal Request form.

## Student Instructions:

- Complete Sections 1 & 2 of this form using a computer.
- Print the form using the 'Print Form' button.
  - a handwritten form will **not** be accepted.
  - an incomplete form, or a form without the required documents attached will not be processed and will be returned to you for completion.
- Sign the form in Section 3; a digital signature is **not** acceptable.
- Attach the following documents located on the Marquette Central web page (Forms - Academic):
  - The Medical Withdrawal Release form (to be used should university personnel need to speak to the health care provider).
  - Other required documentation.
- Submit the forms/documentation via one of the methods listed at the bottom of this form.

**Note:** The information provided by this release must be provided by a licensed healthcare provider and will be kept in the strictest of confidence and used only as necessary when making a determination of the specific medical withdrawal listed below. If sufficient information to make a decision about the medical withdrawal is not provided in the statement from the healthcare provider, a representative from the Medical Withdrawal Committee may contact the student's healthcare provider for more information.

## Section 1: Student Information

Name \_\_\_\_\_ MUID \_\_\_\_\_  
*Last name, First name, Middle name*

Mailing Address \_\_\_\_\_  
*street, city, state, zip code*

Phone \_\_\_\_\_ Email \_\_\_\_\_ @marquette.edu

## Section 2: Licensed Healthcare Provider Information

Full Name \_\_\_\_\_

Title \_\_\_\_\_ Clinic/Hospital Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ Phone \_\_\_\_\_

## Section 3: Statement and Signatures

I, the above name student, have applied for an official medical withdrawal from Marquette University on \_\_\_\_\_ for the following medical reason(s)  
*date of submission*

\_\_\_\_\_ and hereby authorize the above named healthcare provider to release to a member of the Medical Withdrawal Committee, any information contained in my records relating to this specific medical withdrawal or my subsequent return to Marquette University, should further information be needed to act upon my request.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_