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

ADDITIONAL INFORMATION REGARDING RELEASE OF PATIENT MEDICAL RECORDS

The Marquette University Medical Clinic 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 patient's signature, unless it is stated in the authorization to release "future records of a specific test, specified clinic appointment and/or administrations 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 patient older or younger than 18 years.

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

    Patient is:

    □ Minor □ Incompetent □ Disabled □ Deceased

    Legal Authority:

    □ Guardian □ Parent of Minor

    □ Legal Representative of Deceased □ Health Care Power of Attorney