Marquette University Medical Clinic
Schroeder Complex, Lower Level
P.O. Box 1881
Milwaukee, WI 53201
Phone: (414) 288-7184 Fax: (414) 288-1664

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*