MARIAN UNIVERSITY
Indianapolis

Consent for Release of Confidential information

Student Health Services

Rev. 4/2010

I, ____, (Date of Birth or SSN)_________________

Address: campus / home ____

Phone Number: cell / campus / home ____

authorize ____
Name of person(s)/organization making disclosure
to disclose to ____
Name of person(s)/organization

__________ any and all information pertinent to my health and well-being. **OR**

__________ limited information: Please explain the limitation: eg. Information obtained within a range of dates; information concerning a particular condition. ________________________________

____

____

If requested, information may be faxed: _____ Yes (your initials) ________ No (your initials)

I understand that my records are protected under the Marian University Notice of Privacy Practices and cannot be disclosed without my written consent unless otherwise delineated in the Notice. I also understand that I may revoke this consent at any time except to the extent that action has already been taken.

This consent will expire at the end of the current school year (first class day of fall semester to end of last day of final examinations for spring semester) unless specified otherwise: ________________________.

____
Signature of Client Date

____
Signature Of Parent, Guardian Or Legal Representative Date
If Client Under 18 Years Old

____
Signature of Witness Date