

**MARIAN UNIVERSITY**  
— Indianapolis —

**Consent for Release of Confidential Information**  
Marian University Student Health Center

I, \_\_\_\_\_, (Date of Birth or SSN) \_\_\_\_\_

Address: campus / home \_\_\_\_\_

Phone Number: cell / campus / home \_\_\_\_\_

authorize \_\_\_\_\_  
Name of person(s) organization

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 summer 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