MILWAUKEE BALLET | SUMMER INTENSIVE

Authorization for Release of Protected Health Information

Due March 15, 2025

Please print all information clearly**. A copy of the front & back of your health insurance card must be included with this form (one sheet of one-sided 8.5x11 paper).** Be sure your health insurance policy provides for out of town routine and emergency care. If it does not, you must take out a temporary rider.

STUDENT FIRST NAME _____ **LAST NAME** _____ **BIRTHDATE** _____

TELEPHONE: (_____) _____

MAILING ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

AUTHORIZATION. I authorize information to be released from Froedtert & Medical College of Wisconsin, Children's Hospital, Columbia-St. Mary's Hospital, and all other health care providers ("Providers") to the Milwaukee Ballet and its staff (collectively, "Milwaukee Ballet") so that the Milwaukee Ballet can assist in obtaining medical care and treatment for the Student.

INFORMATION TO BE DISCLOSED: All information relevant to the medical care and treatment of the Student, including without limitation, provider notes, consultations, radiology reports, laboratory reports, immunizations, prescriptions, tests and results. This may include, to the extent relevant, substance use disorder records, mental health records, HIV test results and related treatment, and genetic information.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that this Authorization is voluntary. I may revoke this Authorization by providing my revocation by notifying Milwaukee Ballet or the Providers in writing, except to the extent that action has been taken in reliance upon my Authorization. I understand that information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy laws. I understand that the Providers may not condition treatment, payment, enrollment or eligibility for benefits upon execution of this Authorization. I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the Authorization.

EXPIRATION: This Authorization expires one year from the date of my signature below.

By signing this Authorization, I am authorizing the release of all records applicable to this request as outlined above.

Student Signature _____ **Date** _____

Parent(s)/Guardian, Printed _____ **Date** _____

Legal Authority with regard to Minor student: ☐ **Parent*** ☐ **Legal Guardian**

Parent(s)/Guardian Signature _____ **Date** _____

*By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order.

EMAIL ALL DOCUMENTS TO MBFORMS@MILWAUKEEBALLET.ORG

MILWAUKEE BALLET | 128 N JACKSON ST, MILWAUKEE, WI 53202
Phone: 414-902-2100