

MANCHESTER UNIVERSITY HEALTH SERVICES

604 E. College Avenue
North Manchester, IN 46962

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize Manchester University Health Services, to use and/or disclose certain protected health information (PHI) about me to the following individual(s):

Name

Relationship

Name

Relationship

Name

Relationship

This authorization includes but is not limited to disclosure of information by phone, mail, or other means of communication unless otherwise stated.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Health Services at Student Life in Chinworth 103. This authorization is in effect until date of graduation unless written notice is given.

Signed by: _____
Signature of Patient Date

Legal Guardian Name Date

Printed Patient/Legal Guardian

CONFIDENTIAL