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 the Director of Health Services 604 East College Ave., North Manchester, Indiana 46962. 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