Eastern Mennonite University Health Services

Authorization for Use or Disclosure of Health Information

Name (please print):_____ **Date of Birth**: _____

I hereby authorize use or disclosure of my protected health information as described below by:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

1. The following person or facility may receive disclosure of protected health information about me:
   Eastern Mennonite University Health Center
   1200 Park Road
   Harrisonburg VA 22802
   Phone: 540-432-4308
   Fax: 540-432-4099
2. The specific information that should be disclosed:
   _____Lab _____Office Notes _____x-ray _____Immunizations

   _____Other: (please specify) _____

   Dates: from ___/___/___ to ___/___/___

3. I understand that the information used or disclosed may be subject to redisclosure by the person or facility receiving it, and would then no longer be protected by federal privacy regulations.

4. I may revoke this authorization by notifying EMU Health Services in writing. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

5. This authorization expires ONE YEAR from the date of the signature, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:_____.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

_____	_____
Signature of Individual	Date of Signature

OR, if applicable

_____	_____	_____
Signature of Guardian or Personal Representative	Date of Guardian's/Personal Representative's Signature	Description of authority to act for the individual