920 County Line Road, Suite B
Batesville, Indiana 47006

Medical Information & Privacy Notice

I,_____ hereby authorize the staff of Southeast Indiana Health Center to give the following person or persons all information concerning my health and well being.

_____ Spouse / Significant Other Name:_____

_____ Any Specified Person Name:_____

_____ I may be contacted by mail with issues regarding my health

_____ You may leave a message on my answering machine / voice mail

Other :_____

I understand I may revoke this consent at any given time, by giving written notice to the person or organization making the disclosure

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of the Notice of Privacy Policy, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice. Further, I permit a copy of this authorization to be used in place of the original.

Signed:_____ Date:_____

Witness:_____ Date:_____