Hope College Student Health Center

Consent for Exchange of Medical Information

I hereby authorize Hope College Health Center to obtain or disclose the following protected health information (PHI):

Description of information:_____

_____

This PHI may be released

TO:_____ **FROM:**_____

_____ _____

_____ _____

This disclosure is being made for the following reason:

( ) At the request of the patient.
( ) Other:_____

This authorization shall be in effect until the above PHI has been processed unless specific expiration date is given below:

( ) One time consent only.
( ) Ongoing consent, expires:_____

I understand that I have the right to:

- Inspect or copy my PHI to be used or disclosed as permitted under federal law.
- Refuse to sign this authorization.
- Revoke this authorization in writing at any time by sending notification to:

  Hope College Health Center
  168 E. 13th Street, P.O. Box 9000
  Holland, MI 49422-9000
  Fax: 616-395-7144

_____ _____
Printed name of patient Date of birth

_____ _____
Signature of patient Date of signature

_____
Witness

☐ I am a current Hope student
☐ I attended Hope from _____ to _____
Month/year Month/year

Maiden name used at Hope if different from above:_____