

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: _____

