Hope COLLEGE
HEALTH CENTER

CONSENT FOR THE RELEASE OF PERSONAL HEALTH INFORMATION

I authorize the following personal health information to be released pertaining to the diagnosis/condition of:_____

- ☐ Summary of Care (Provider notes, imaging reports, medications, labs etc) OR
- ☐ Specific records as indicated:_____

I authorize the release of my records for the dates ranging from: _____to_____

To:_____ From: _____

_____ _____

_____ _____

_____ _____

This information is to be used for the purpose of:

- ☐ Consultation for treatment and/or collaboration of care
- ☐ Historical records review
- ☐ Other:_____

I understand that I have the right to refuse to sign this authorization form and that Hope College Health Center is released from all legal liability that may arise from the release of the information requested. I understand I have the right to inspect or copy my PHI as permitted under federal law. I understand that I may revoke this authorization at any time by notifying Hope College Health Center.

This authorization is for:

- ☐ Single disclosure
- ☐ Continuing disclosure, valid until_____(expiration date)

Printed Name:_____Date of Birth:_____

Signature of patient: _____Date of Signature:_____

Witness:_____