HOUGHTON COLLEGE STUDENT HEALTH CENTER
One Willard Ave, Houghton, NY 14744
Tel: 585-567-9483 · Fax: 585-567-4303

Consent to Send or Receive Health Information

Patient Name (Print):_____

Previous or Maiden Name_____

Current Address:_____

Date of Birth:_____Tel:_____Cell:_____

Please complete Either A or B below

A. I HEREBY AUTHORIZE THE **STUDENT HEALTH CENTER** OF HOUGHTON COLLEGE TO **RELEASE** THE FOLLOWING INFORMATION:

_____
_____

TO:
Person/entity:_____
Address:_____
Telephone: _____ Fax: _____

B. PLEASE RELEASE THE FOLLOWING INFORMATION **TO** THE **STUDENT HEALTH CENTER** AT HOUGHTON COLLEGE:

_____
_____

FOR THE PURPOSE OF:

_____
_____

I UNDERSTAND *that there is a potential for this information, once disclosed, to be re-disclosed outside the protection of the Student Health Center.*
I AGREE *that a photographic or facsimile copy of this authorization is as valid as the original.*
I KNOW *that I may request a copy of this authorization.*
I UNDERSTAND *that I have the right to revoke this authorization, in writing, at any time.*

SIGNATURE: _____ DATE: __/__/__

WITNESS: _____ DATE: __/__/__

Rev. 5/09 grs