Powell Student Health Clinic

Phone: (479) 788-7444 Fax: (479) 788-7436 E-Mail: StudentHealth@uafs.edu

Today's Date:_____ Phone: _____ E-Mail: _____

Name:_____SSN#:_____
Last First MI

Address:_____
Street City, State, Zip

Birthdate: _____ Ethnicity: _____ Sex:_____

Emergency Contact:_____
Name Phone Number Relationship

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What are you being seen for today:_____

Medication Allergy: ‰N/A _____ Food Allergy: ‰N/A _____

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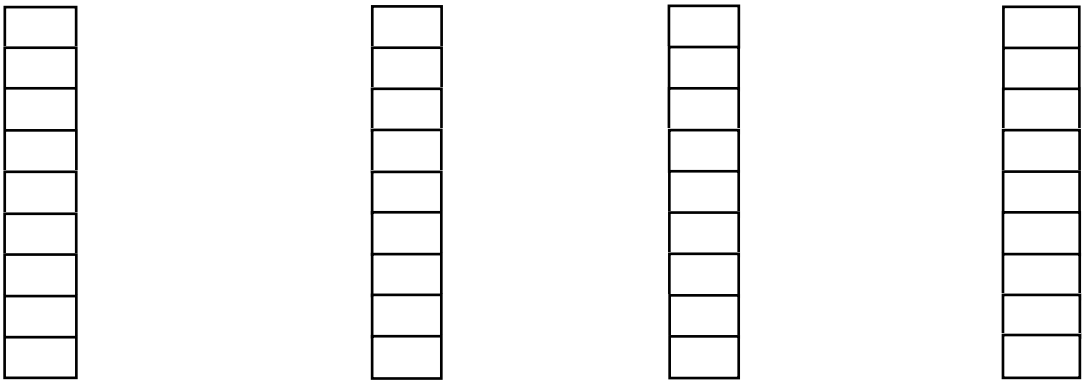

Authorization to Release information for treatment, payment or healthcare operations

I hereby authorize the release or use of my individually identifiable health information (Protected Health Information or PHI) and medical information by Powell Student Health Clinic in order to carry out treatment, payment or healthcare operations.

You retain the right to request that we further restrict how your PHI is released or utilized to