Student Health & Wellness Center

1100 Henderson Street ● HSU Box 7740● Arkadelphia, AR 71999
Phone: 870-230-5102 Fax: 870-230-5064

PERMISSION TO RELEASE/TRANSFER MEDICAL INFORMATION

"I hereby authorize HSU Student Health & Wellness Center to release/transfer the following information from my confidential health records:"

(check the appropriate box, please)

- □ **Copy of Immunization Records**
- □ **Copy of TB skin test results**
- □ **Copy of proof of flu shot**
- □ **Other_____**

****Photo ID REQUIRED**
(send a photocopy of school ID or driver's license with release)
Request will not be processed without photo ID

Please complete all the following information:
Your FULL name as found on Permanent files at HSU:_____
Maiden Name (if applicable)_____
HSU ID number:_____
Your Phone Number:_____
Your current address_____
Your date of birth_____
Are you an HSU student now? Yes No If no, give dates last attended HSU_____

PLEASE RELEASE MY CONFIDENTIAL RECORDS TO:

_____SELF _____EDUCATIONAL FACILITY _____OTHER

Reason for release: _____transferring _____work _____health related _____other

Name of location you want your records sent:_____
Specific person/department that will receive your sent records: _____
How would you like your records sent?
___Email: Provide receiver's email address here_____
___Fax: Provide receiver's fax number here_____
___US Mail: Provide receiver's complete mailing address here_____
_____

--Records will be sent to only ONE place—a new release form must be completed for each request.

Signature_____

Print Name_____

Today's Date_____

Requests will be processed during the regular workweek as time allows. Allow additional time for requests made on weekends and /or university closings.

NOTE: The consent to release/transfer medical information may be revoked in writing, except to the extent that HSU Student Health & Wellness Center has already taken action in reliance therein.