Student Health Clinic THE UNIVERSITY OF CENTRAL ARKANSAS
Student Health Building – 1st Floor
201 Donaghey Avenue
Conway, AR 72035-0001
Phone: (501) 450-3136
Fax: (501) 450-3370

PERMISSION FOR RELEASE OF INFORMATION

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Student Health Clinic of the University of Central Arkansas requires your written consent before disclosing any personal information. Your consent to share this information may be withdrawn in writing at any time, so long as such documents are specific as to information covered, dated, and signed.

Note: Any information shared pursuant of this consent may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule.

I, _____, ID# _____,
(Print Name) (DOB, Student ID#, or SSN)

Request that the University of Central Arkansas Student Health Clinic, or

_____
Name of Institution/Business

Release the following information from my health record: (Check all that apply)

❑ Immunization Record ❑ Lab Results ❑ Women's Health Record ❑ Entire Medical Record

❑ Care delivered on specific date ___ / ___ / ___ ❑ Care delivered for _____ only.
(Specific illness/injury)

This information is to be released to:

❑ Student Health Clinic
University of Central Arkansas
Student Health Building – 1st Floor
201 Donaghey Avenue
Conway, Arkansas 72035-0001
Ph#: (501) 450-3136
Fax#: (501) 450-3370
E-mail: shc@uca.edu

OR:

_____
Name

_____
Address

_____
City/State/Zip

_____
Telephone Number

_____
FAX Number

_____
E-mail Address

_____
Patient's Signature Date

_____
Contact Info (used only for questions regarding above request)

_____
Witness By (SHC Staff)