Ouachita Baptist University
Health Services

410 Ouachita Street
OBU Box 3687
Arkadelphia, AR 71998
Phone: 870-245-5244
Fax: 870-245-4558

PERMISSION TO RELEASE/TRANSFER MEDICAL INFORMATION

I, _____, hereby request OBU Health services to release/transfer the following information from my health files:

_____ Immunization Records
_____ TB test results
_____ Allergy Information
_____ Other_____

RELEASE RECORDS TO:

Name: _____

☐ ***Email:** _____

☐ **Address:** _____

☐ **Fax number:** _____

*I understand that email is not always secure, but I request that my records be sent this way.

Student Information:

Phone Number: _____

OBU ID # _____ **Date of Birth** _____

Current Student Y N if no, give dates last attended OBU _____

_____	_____	_____
Print Name	**Signature**	**Date**

Expiration Date to release Information. _____

**Your consent may be withdrawn in writing at any time, so long as OBU Health Services has not taken action on such documents*

Office use only:	Completed Y N	Date: _____