***Complete Form, Print, Sign and return to Health & Wellness Center***

**ARKANSAS TECH UNIVERSITY**
**HEALTH & WELLNESS CENTER**
**PERMISSION FOR RELEASE OF INFORMATION**

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 Your consent to share this information may be withdrawn in writing at any time, so long as such documents are specific as to information covered, dated and signed.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

**I, _____ ID#_____**
**Print Name**

**Request that Arkansas Tech University Health & Wellness Center, or**

_____
**Name of Institution/Business**

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

_____Lab results _____Immunization records _____Entire medical record

_____Care delivered on this specific date only _____/_____/_____

_____TB Skin Test _____Care delivered for _____ only.
Specific illness/injury

**This information is to be released to:**

**Health & Wellness Center**
**Arkansas Tech University**
**402 West "O" Street**
**Dean Hall, Room 126**
**Russellville, AR 72801**
**479-968-0329**
**Fax 479-967-6610**

**OR**

_____
**Name**

_____
**Address**

_____
**City/State/Zip**

_____
**Telephone Number**

_____
**Fax Number**

_____ _____
**Signed** **Witness**

_____
**Date**