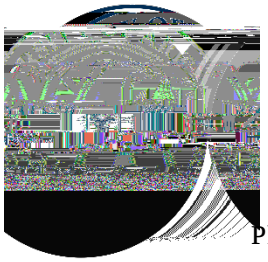

University of Arkansas at Fort Smith

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

What are you being seen for today: _____

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

Current Medications: Include supplements and over the counter taken within the past 48 hours. N/A

_____ _____

_____ _____

Diet: Please list dietary restrictions: (e.g. lactose intolerance, vegan, celiac): N/A _____

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 carry out treatment, payment or healthcare operations. Our practice is not required to agree to such requested restrictions, however if we do agree to our requested restrictions, such restrictions are then binding on the Notice of Privacy Practices.

Notice of Privacy Practices

EFFECTIVE DATE: