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: _____

Address: _____

Fax number: _____

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******Your consent may be withdrawn in writing at any time, so long as OBU Health Services has not taken action on such documents.*