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: