University of Alabama in Huntsville
Student Health Center

Allowance for Confidential Communications To A Third Party

Name of Student _____ Date of Birth _____
(Please print)

A# _____

I grant permission for the UAHuntsville Student Health Center to give information with regard to my medical care to the following person(s) or entity(ies). I understand that I may withdraw, in writing, one or all of these requests at any time.

Name of person given permission to receive Medical information:	Relationship to patient (friend, spouse, other family member, or physician):
_____	_____
_____	_____

I grant permission for the UAHuntsville Student Health Center to leave messages as designated below:

APPOINTMENT/REMINDER/CHANGES			TEST RESULTS	
Home Phone	YES	NO	YES	NO
Work Phone	YES	NO	YES	NO
Cell Phone	YES	NO	YES	NO

Patient Signature _____ Date _____

Witness Signature _____ Date _____