Arkansas Northeastern College

P.O. Box 1109, Blytheville, AR 72316
870-762-1020

Authorization to Request/Obtain Immunization Records

Please complete this entire form and print clearly.

I authorize Arkansas Northeastern College to request/obtain my immunization records from:

_____ Arkansas Department of Health
_____ Missouri Department of Health

_____	_____	_____
Last Name	First Name	Middle Initial
_____	_____	_____
Social Security Number	Date of Birth	Maiden Name
_____		_____
Physical Address		Phone Number
_____		
City, State & Zip		

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been obtained). This Authorization will automatically expire one (1) year from the date of this request or on the following requested date: _____.

_____	_____
Student Signature	Date
_____	_____
Parent or Guardian Signature (If student is under the age of 18)	Date

This form cannot be used for the re-release of confidential information provided or obtained by ANC's Admissions Office from other individuals or agencies.

Office Use Only

Date Received: _____ Staff Initials: _____

Date Completed: _____ Staff Initials: _____

**** Disclosure requirement – must keep in student file.***