

ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: **SMITH, MARVIN ISAIAH**

DOB: **01/23/1997**

Chart #:

Date of Service: **04/02/2020**

Vaccine Family	Type of Vaccine (no Brand Name)	Date Given (mm/dd/yy)	Age at Adm	Dose (cc/mL)	Route & Site	Mfr.	Lot #	VIS Date	Vaccinator Signature
Tetanus, Diptheria, (Pertussis) (e.g., Td, Tdap)	DTP-HIB	03/25/97	2 m	0.5					
	DTP-HIB	05/28/97	4 m	0.5					
	DTAP	08/28/97	7 m	0.5					
	DTAP	03/12/98	13 m	0.5					
	DTAP	02/20/01	4 y	0.5	RA				OUTSIDE CLINIC
	TDAP	08/02/11	14 y	0.5		SKB	AC52B063BA		OUTSIDE CLINIC
Hepatitis A (e.g., HepA, HepA-HepB)	HEP A	08/02/11	14 y	0.5		SKB	AHAVB498BB		OUTSIDE CLINIC
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PED	01/24/97	0 m	0.5					
	HEP B ADOL/PED	03/25/97	2 m	0.5					
	HEP B ADOL/PED	08/28/97	7 m	0.5					
Human Papillomavirus (e.g., HPV)									
Measles, Mumps, Rubella (MMR, MMRV)	MMR	02/16/98	12 m	0.5					
	MMR	02/20/01	4 y	0.5	RA	MSD	0162K		OUTSIDE CLINIC
Meningococcal (MCV4, MPSV4)	MCV4P (MENACTRA)	08/02/11	14 y	0.5		PMC	U3763AA		OUTSIDE CLINIC
Pneumococcal (e.g. PCV, PPV)	PCV7	02/20/01	4 y	0.5	LA				OUTSIDE CLINIC
Polio (e.g., IPV, DTaP-HepB-Hib)	OPV	03/25/97	2 m	0.5	PO				
	OPV	05/28/97	4 m	0.5	PO				
	OPV	08/28/97	7 m	0.5	PO				
	IPV	02/20/01	4 y	0.5	LA				OUTSIDE CLINIC
Varicella (Var, MMRV)	VARICELLA	04/20/00	3 y	0.5					
	VARICELLA	08/02/11	14 y	0.5					OUTSIDE CLINIC
Influenza (e.g., TIV, LAIV)									
Zoster									
Other	HIB UNS	08/28/97	7 m	0.5					
	HIB UNS	02/16/98	12 m	0.5					

AUM STUDENT HEALTH SERVICES
7461 EAST DRIVE
RM 102 MOORE HALL
MONTGOMERY, AL36117
334 2443281

PPD	Date	Results	PPD	Date	Results
Mantoux			Mantoux		
Mantoux			Mantoux		
Mantoux			Mantoux		

TRANSMISSION VERIFICATION REPORT

TIME : 04/02/2020 14:05
NAME : AUM
FAX : 3342443396
TEL :
SER.# : BR0D8J659256

DATE, TIME
FAX NO./NAME
DURATION
PAGE(S)
RESULT
MODE

04/02 14:03
9161589341629741319
00:01:55
04
OK
STANDARD

P.O. Box 244023
Montgomery, AL 36124
Phone: 334-244-3281
Fax: 334-244-3396



**AUBURN UNIVERSITY
AT MONTGOMERY**

STUDENT HEALTH SERVICES

Attn: Tandra Gause

To: Primary Care + Hope Clinic

From: AUM Student Health

Fax: 615-893-4162

Pages: 4

Phone: 615-893-9390

Date: 04/02/2020

Re: M. Smith

cc:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

F A X S H E E T

Date: Apr-02-2020 09:09:58
To: AUBURN UNIVERSITY AT MONTGOMERY- STUDENT
HEALTH SERVICES CLINIC
Subject: ROI
Fax Number: 3342443396
To
Company:
From Name: Gause,Tandra
From
Company: Primary Care and Hope Clinic
From
Facility: Primary Care and Hope Clinic
Support
Contact: 615-893-9390
Number of
Page(s): 3

This facsimile transmission contains confidential information intended for the parties identified above. If you have received this transmission in error, please immediately notify me by telephone and return the original message to me at the address listed above. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.

PRIMARY CARE AND HOPE CLINIC
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

I, Garvin Smith, authorize Primary Care & Hope clinic to use / disclose or receive the following protected health information concerning:

PATIENT NAME <u>Garvin Smith</u>	SSN: <u>410-47-5940</u>	DATE OF BIRTH: <u>01/08/1997</u>
Information to be disclosed by:	And is to be provided to:	
NAME OF FACILITY <u>Auburn University at Montgomery</u>	NAME OF PERSON/ORGANIZATION/FACILITY PRIMARY CARE AND HOPE CLINIC	
ADDRESS <u>7430 East Dr Montgomery AL</u>	ADDRESS 1453 HOPE WAY	
CITY/STATE/ZIP <u>Montgomery AL 36117</u>	CITY/STATE/ZIP MURFREESBORO, TN 37129	
PHONE #: <u>334-244-3000</u> FAX #: <u>334-244-3396</u>	PHONE #: 615-893-9390	FAX #: 615-893-4162

☐ I request records be sent via unencrypted e-mail, I acknowledge and accept the risk of access by a 3rd party while in transit. Initial: _____

Reason for disclosure:

- | | | |
|--|------------------------------------|---------------------------------------|
| ☐ Personal Use | ☐ Insurance | ☐ Attorney |
| ☒ Further Medical Care | ☐ School | ☐ Other: _____ |

Information to be disclosed:

- | | | |
|--|--|---|
| ☐ Last 2 years office notes | ☐ Most recent pap smear | ☐ Other information related to (include dates):
<div style="border: 1px solid black; height: 60px; width: 100%;"></div> |
| ☐ Last 2 years laboratory results | ☐ Most recent colonoscopy | |
| ☐ Last 2 years imaging results | ☐ Most recent mammogram | |
| ☒ Immunization record | ☐ Entire record | |

If the information to be disclosed contains any records related to the types of information below, additional laws regarding use and disclosure may apply. I understand and agree that this information will be disclosed only if I place by initials in the applicable box(es) below:

Alcohol/Drug Abuse diagnosis, treatment, or referral

Psychotherapy notes ONLY (by initialing I am waiving any psychotherapist-patient privilege)

Other Mental Health Information

Sexually transmitted diseases

Genetic testing information

HIV/AIDS information

I understand that I am not obligated to sign this authorization and refusing to do so will not adversely affect my ability to receive health care services unless the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of all or some of this information including HIV/AIDS, mental health, genetic testing and drug/alcohol diagnosis, treatment or referral information.

I understand that I may revoke this authorization in writing at any time to the Primary Care & Hope Clinic. If authorization is revoked, the information described above may no longer be used or disclosed for the purposes of this written authorization, however, any use or disclosure made prior to any revocation cannot be undone. This authorization will expire in one year unless an expiration date or event is listed below.

I have read this authorization and understand it:

Garvin Smith
Signature

4/2/20
Date

Relationship to Patient if signing as Patient Representative

[Signature]
Witness/Verification of Identification

Expiration date/event - if blank will expire in 1 year

4-2-20
Date