



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

Patient Information Update Form
(Please Print Legibly)

Date: 20 OCT 2023 Student Number: 9031087 Birthdate: 18 JAN 1982

Last Name: TAMAYO First Name: LORINA

Phone Number: 562-458-0429 AUM Email: lorina.tamayo@aum.edu

Local Address: 2147 COLLEGE ST Box or APT#: _____

City: MONTGOMERY State: AL Zip Code: 36106

Marital Status: Single ☐ Married ☐ Divorced ☒ Widowed ☐ Other: _____

Primary Physician: DR. LOIS SCHULMAN City: MGM Phone #: 334-279-9211

Emergency Contact: GOLDEEN TAMAYO Relationship: SISTER Phone# 916-600-1622

Insurance Information

Do you have health insurance? Yes ☒ No ☐

If Yes, please give your card to the front desk in order for a copy to be made for your chart.

Insurance Company: BCBS Policy or Contract Number: QAU896878204

Group Number: 37655 Policy Holder Name: LORINA A. TAMAYO

Policy Holder Date of Birth: 18 JAN 1982 Relationship to Policy Holder: self

Insurance Company Address: _____

Medical History

Do you have any allergies, medical conditions, or procedures: (Include hospitalization, illnesses, and surgeries)

seasonal allergies, asthma
hysteroscopy - Sept 2022, 2014

Please list any medications you are currently taking:

Claritin, 10mg, 1x/day _____
Albuterol - as needed _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involve in my treatment)
- Obtaining payment from third party payers (e. g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Summary of the HIPAA Privacy Rule, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

General Consent for Treatment

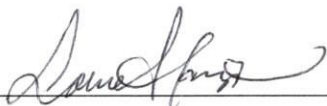
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Warhawk Health Services. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Signature:  Date: 10 / 20 / 2023

Print Patient's Name: LORINA TAMAYO

Relationship to Patient (if you are the patient, write "self"): self

Warhawk Health Services
Medical Information Release Form (HIPAA Release Form)

Name: LORINA A TAMAYO Date of Birth 01 / 18 / 1982

Release of Information

☒ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

Name: Dr. Lois SCHOLMAN Phone: 334-279-9211 Relationship: Primary care

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☒ my cell number: (562)-458 - 0429

If unable to reach me:

- ☒ Please send me an email ☐ Please leave me a message to return your call
☐ Please leave me a detailed message ☐ Other

The best time to reach me is:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

☒ Morning ☐ Early Afternoon ☐ Late Afternoon ☐ Anytime

Signature: 

Date: 10 / 20 / 2023