



**AUBURN UNIVERSITY  
AT MONTGOMERY**

**STUDENT HEALTH SERVICES**

**Patient Information Update Form  
(Please Print Legibly)**

Date: 8/28/2019 Are you an AUM Student? Yes ☐ No ☒ Student Number: \_\_\_\_\_

Name: Karen Griffin Preferred: Karen Birthdate: 7/26/1961

Phone Number: 334-669-0181 Email: kgriffi9@aum.edu

Local Mailing Address: 128 Rutherford Ct. Box or APT#: \_\_\_\_\_

City: Wetumpka State: AL Zip Code: 36093

Marital Status: Single ☐ Married ☒ Divorced ☐ Widowed ☐ Other: \_\_\_\_\_

Primary Physician: River Region Family Medicine City: Wetumpka Phone #: 567-3309

Emergency Contact: Daniel Griffin Relationship Husband Phone# 334-595-2151

**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: Blue Cross/Blue Shield Name of Policy Holder: Daniel R. Griffin

Policy or Contract Number: EIB901240276 Group Number: 13000

Insurance Company's Address: 450 Riverchase Parkway, East, Birmingham, AL 35244

**Medical History**

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

Hashimoto's high blood pressure

Are you taking any medications regularly at the present time *(including allergy injections, antidepressants, contraceptives, over-the-counter drugs, etc.)*? Yes ☒ No ☐

If yes, please list Synthroid (150mcg), Lisinopril(20mg)  
(Not Generic)

Preferred Pharmacy and Phone number: Walgreens 334-514-7135

*AUM Student Health Services*  
*Medical Information Release*  
*Form (HIPPA Release Form)*

Name: Karen Griffin Date of Birth 07 / 26 / 1961

**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:

- ☒ Spouse: Daniel R. Griffin  
☐ Child(ren): \_\_\_\_\_  
\_\_\_\_\_  
☐ Other: \_\_\_\_\_  
☐ 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: (334)-669 -0181

If unable to reach me:

- ☒ you may leave me a detailed message  
☐ please leave a message asking me to return your call  
☐ other: \_\_\_\_\_

The best time to reach me is (day or days) anytime between \_\_\_\_\_ and \_\_\_\_\_ times.

Signed: Karen Griffin  
Date: 8/28/19

# AUM STUDENT HEALTH SERVICES

## CONSENT FOR SERVICES FORM

Patient Name: Karen Griffin Date of Birth: 07/26/61  
Day Month Year

### 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 Student Health Center. 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.

Karen Griffin

Signature of Patient

8/28/19  
Day Month Year

Date of Signature

\_\_\_\_\_  
Signature of Legal Representative (if patient is unable to sign)

\_\_\_\_\_  
Relationship to Patient

**See Back of Form**

# AUM Student Health Services

## PATIENT HIPPAA 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 (HIPPA). 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 HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. 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.

Signed this 28<sup>th</sup> day of August 2019.  
(day) (month) (last two digits of the year)

Print Patient's Name: Karen Griffin

Signature: Karen Griffin

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