

Sargent, Hollen Ham
AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 6/27/17 Are you an AUM student? ☒ YES ☐ NO Student ID # S00132355

Name: Hollen Ashley Sargent

Social Security Number: 416-43-9204 Birth Date: 6/19/94

Local Phone Number: 657-0564 Alternate Number: _____

Local Address: 106 Cleveland Dr Box Number _____

City: Wetumpka State: AL Zip Code: 36093

Permanent Address: 4365 Jug Factory Rd

City: Wetumpka State: AL Zip Code: 36093

Marital Status (Please Circle): ☒ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Sex (Please Circle): ☐ Male ☒ Female

Primary Physician: Spencer Coleman City: Wetumpka Phone #: 567-7850

Patient's Employer: Pet Care Center Work #: 281-4011

Parent's or Spouse's Name (Circle which) ☒ Parent ☐ Spouse Paula Sargent Phone #: 657-0692

Parent's or Spouse's Employer: Self Employed Work #: 567-5344

Emergency Contact: Roger Sargent Relationship: Father Phone #: 657-6237

How did you hear about the Clinic? Friend ☒ Faculty/Staff ☐ Orientation ☐ Other _____

INSURANCE INFORMATION

Do you have health insurance? ☒ YES ☐ NO

If yes, please give your card to the receptionist in order for a copy to be made for your chart.

Insurance Company: BCBS Name on Card: Paula Sargent

Policy Number: P6X832260136 Group Number: 91005

Insurance Company Address: 450 Riverchase Parkway East
Birmingham AL 35244

AUM Student Health Services 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 involved 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 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 to 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 27 day of June 2017.

Print Patient Name Hollen A Sargent

Signature H Sargent

Relationship to Patient Self

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

Name: Hollen A Sargent Date of Birth 6/19/1994

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: _____

☐ Child(ren): _____

☒ Other: Paula or Chip Sargent

☐ 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) - 657 - 0564

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) Monday - Sunday between 9:00 am and 8:00 pm times.

Signed: H A Sargent

Date: 6/27/17