

Zerrington Hinson  
6650 County Road 33  
Letohatchee, AL 36047-5757

RE: Employer: Auburn University  
Date of Injury: 04/10/2023  
Our Claim No: WC20230005324

**MEDICAL PROVIDER INFORMATION**

1. NAME: AUM Warhawk Student Center  
ADDRESS: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_
2. NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_
3. NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_
4. NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_
5. NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_

**PHARMACY INFORMATION:**

NAME: CVS Pharmacy  
ADDRESS: 4790 Mobile Hwy Montgomery, AL 36108  
PHONE NUMBER: (334) 281-4119

TO: \_\_\_\_\_

Name: Zerrington Hinson DOB: 9/16/93 SSN: 420-413433 Claim Number: WC20230005324

For informational purposes pertaining to an insurance claim, I, Zerrington Hinson, hereby authorize all health care providers, physicians, hospitals, clinics and institutions, medical facilities, mental health clinics, mental health hospitals and pharmacies, to release all existing medical records and information regarding my medical care, treatment physical/mental condition and medical expenses revealed by your observation or treatment of past, present and future to: **Brentwood Services Administrators**

I understand that this authorization includes information regarding the diagnosis and treatment of drug, alcohol, Acquired Immune Deficiency Syndrome (AIDS), and psychiatric and psychological disorders (EXCEPT Psychotherapy Notes\* as defined by the Health Insurance Portability and Accountability Act 45 CFR 164.501, psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health profession documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's record). It also includes x-rays, reports, progress notes, photographs, lab reports, medical reports, and any and all other documents of any kind which you have in your possession concerning or relating to any injury, treatment or disability sustained by me. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputed, resolutions and payments and medical records provided as evidence of services provided. This listing is not meant to be exclusive.

I, the undersigned individual, am on notice that:

- Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the individual.
- Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.
- This authorization can be revoked through written notice to the individual above listed entities, except to the extent that action has been taken in reliance on this authorization. The undersigned is aware of the potential that protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.
- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect for one (1) year from the date of this authorization.

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

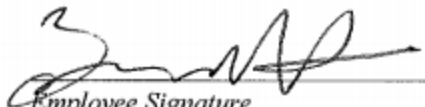
4-23-2023  
Date

[Signature]  
Signature

# Notice of No Health Coverage

Re: Auburn University's OJI Program  
Employee: Hinson, Zerrington  
Date of Injury: 04/10/2023  
Claim Number: WC20230005324

I, Zerrington Hinson was not covered under any medical insurance policy (either under a policy at Auburn University, my parent's insurance coverage, my spouse's insurance coverage at his /her place of employment nor any federal or state programs) at the time of the above injury, which I reported while working for Auburn University.

  
\_\_\_\_\_  
Employee Signature

4-23-2023  
\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date