

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 8-28-17 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Anna Caroline Rives

Social Security Number: 412-47-6112 Birth Date: 09-14-97

Local Phone Number: (334) 452-0762 Alternate Number: (334) 649-0877

Local Address: 124 Harrogate Springs Rd Box Number _____

City: Westumpka State: AL Zip Code: 36093

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☒ Female ☐

Primary Physician: Dr. Drumbull City: MGM Phone #: (334) 273-9700

Patient's Employer: _____ Work #: _____

Parent's or Spouse's Name (Circle which) Ashley Rives Phone #: (334) 649-0877

Parent's or Spouse's Employer: Hill Hill Carter Work #: (334) 834-7600

Emergency Contact: Bobby Rives Relationship: Father Phone #: (334) 324-0063

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: BZBS Name on Card: Robert D. Rives

Policy Number: PPA842009711 Group Number: 15731

Insurance Company Address: 450 River Chase Pkwy. E
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 28th day of August 2017.

Print Patient Name Anna Rives

Signature Anna Rives

Relationship to Patient Self

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

Name: Anna Caroline Rives Date of Birth 09/14/97

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: parents - Ashley & Bobby Rives

☐ 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)-452-0762

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) any between _____ and _____ times.

Signed: Mr. Z. Rives

Date: 08/28/17

Patient Name Anna Caroline Rives Date of Birth 09/14/97

Relationship to Patient