

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 08/21/2013 Are you an AUM student? ☒ YES ☐ NO Student ID # 500485701

Name: Paula Diaz

Social Security Number: _____ Birth Date 02/27/95

Local Phone Number: 832 677 5036 Alternate Number: _____

Local Address: AUM Box Number 569 968

City: Montgomery State: Alabama Zip Code: 36124

Permanent Address: Urb. Agua Miel. La Rosaleda Casa #35. Venezuela

City: Barquisimeto State: Zarza Zip Code: 3001

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

Sex: Male ☐ ☒ Female (Please Circle)

Primary Physician: _____ City: _____ Phone #: _____

Patient's Employer: _____ Work #: _____

Parent's or Spouse's Name (Circle which) _____ Phone #: _____

Parent's or Spouse's Employer: _____ Work #: _____

Emergency Contact: Oscar Diaz Relationship: Father Phone #: 158424588564

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.

CONSENT FOR TREATMENT

I am requesting care for myself or my above named dependent and give my consent for treatment. I am responsible for all fees for services incurred at the Student Health Center (Nursing Care Center).

Signature X _____

Signature of patient or parent/guardian, if patient is a minor.

SERVICES CONSENT FORM

NAME: _____

DATE OF BIRTH: _____

I AM REQUESTING CARE FOR MYSELF OR MY ABOVE NAMED DEPENDENT AND
GIVE MY CONSENT FOR TREATMENT. I AM RESPONSIBLE FOR ALL BILLS
INCURRED AT THE NURSING CARE CENTER.

SIGNATURE: _____

DATE: 08/23/2013

SIGNATURE: _____

DATE: _____

SIGNATURE: _____

DATE: 08/19/2014

SIGNATURE: _____

DATE: _____

SIGNATURE: _____

DATE: 03/16/2015

SIGNATURE: _____

DATE: _____

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DATE: _____

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DATE: _____

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

Name: Paula Diaz Date of Birth: 02/27/1995

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 _____

☒ 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: 832 677 5036

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) Monday - Friday between (time) 8:00am - 10:00 pm

Signed: [Signature] Date: 03/16/2015

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 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 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 16th day of March 20 15.

Print Patient Name Paula Diaz

Signature 

Relationship to Patient _____

AUM Student Health Services

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- 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 complete description 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.

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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 3rd day of April 2017.

Print Patient Name Paula Diaz

Signature [Signature]

Relationship to Patient _____

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

Name:

Paula Diaz

Date of Birth:

27/02/95

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Please call ☐ my home ☐ my work ☒ my cell Number: 832 6775036

If unable to reach me:

☐ you may leave a detailed message

☒ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____

between (time) _____

Signed: _____

Date: 04/03/17