

Authorization for Use or Disclosure of
Medical Record Information
Auburn University Medical Clinic



AUBURN
UNIVERSITY

Patient Information

Patient Full Name: Fun Jung Jung

Patient Address: 467 Arnell Lane

City: Auburn State: AL Zip: 36830

Date of Birth: 06/22/1969

Social Security #: 421-53-6269

Home Phone: (334) 244-0256

Cell Phone: (334) 524-5093

Email: julykme@yahoo.com

Release Information To

I hereby authorize Auburn University Medical Clinic (AUMC) to release my medical record information to:

☒ Mail Copies To

☐ Hold for Patient Pick-up

☐ Discuss Medical Information With

Name/Facility: AUM

Attention: _____

Address: 7630 East Drive

Phone: (334) 244-3000

City: Montgomery

State: AL

Zip: 36117

Fax: () -

Purpose of Request:

☐ Personal

☐ Continuing Care (second opinion or refer to specialist)

☒ Insurance

☐ Work Related

☐ Legal

☐ Transfer out/Reason? _____

☐ Other _____

Information to be Released

☒ Please provide a 2 year abstract (includes 5 years of diagnostics)

Copy fee capped at \$25.00 for a 2 year abstract. Notarized additional \$25

☐ Other - Please be specific, include dates and clinicians under comments.

Note: You will be invoiced at the allowable AL Statute rate.

Copy Fee: \$1.00 per page for first 25 pages; \$0.50 per page

for over 25 pages, plus postage (\$3), search fee (\$5), Notarized (\$25)

Comments

AUMC does not provide copies of records received for another physician or institution.
Please request these records directly from the original healthcare provider.

Authorization to Release Protected Information

Required

Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check One.

I ☒ DO

☐ DO NOT want Psychiatric Treatment Notes released.

I ☒ DO

☐ DO NOT want information about Mental Health released.

I ☒ DO

☐ DO NOT want information about HIV Tests & Related Information released.

I ☒ DO

☐ DO NOT want information about Alcohol and/or Substance Abuse released.

I ☒ DO

☐ DO NOT want information about _____ released.

Other sensitive information?



Please confirm that you have put a checkmark and initialed ALL the protected information categories above, regardless if they are applicable or not. If form is incomplete or if protected information is not released we may be unable to fill this request.

Initials

ED
ES
ED
ED
ED
ED

Patients Signature

Date*

1-12-2018

Parent/Legally Recognized Representative Signature

Date

1/12/2018

Witness

Date

E-Mail: aumcmedrecords@eamc.org

Know Your Privacy Rights
Refer to the HIPAA
PRIVACY NOTICE

FAX NUMBER
(334) 528-6780

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Medical Records Department except to the extent that AUMC has already completed action on.

FOR MEDICAL STAFF TO COMPLETE

☐ FAXED ☐ MAILED ☐ HAND DELIVERED COMPLETED BY: _____

DATE: _____

Revised 11/2011

MEDICAL INFORMATION FORM
AUBURN UNIVERSITY
(CONFIDENTIAL)

903764404
RECEIVED

MAY 20 2015

MEDICAL LEGAL DOCUMENT - Property of Auburn University Medical Clinic. Information may not be released to a third party unless a proper acceptable authorization is furnished to the Medical Clinic. This release must comply with State and Federal Regulations. Incomplete or inaccurate information may delay your clearance, cancel your registration, or cause improper decisions of your future medical care.

BEFORE YOU MAIL THIS FORM, be sure to COMPLETE BOTH SIDES...Sign...Have one of your Parents/Guardians Sign

MAIL, FAX or E-Mail TO:

Auburn University Medical Clinic Phone: (334) 844-4416
ATTN: Medical Records Fax: (334) 528-6780
400 Lem Morrison Drive E-Mail: aumcmrecords@camc.org
Auburn University, AL 36849-5349

#408320

GENERAL INFORMATION

Name: Jung Eun Jung Last First Middle Social Security # 421 53 6369
AU User ID/GID 2250019
Home Address: 467 Arnell Lane Student's Cell Phone: 334 524 5093
City: Auburn AL 36830 State: AL Zip: 36830
Date of Birth: 06/22/1969 Sex (circle one) M ☒ F Auburn Email Address:
Emergency Contact - Name: Seong Hee Lee Relationship: Friend
Telephone: HOME: 334 662 6705 WORK: () - () - () CELLULAR: () - () - ()
Address: Street / P.O. Box City State Zip
Authorization for medical clinic to treat a minor student (under 19 years of age):
(Signature of parent or legal guardian)
List Allergies to medication or other items none
Student Starting School: Summer 2015
Semester Year

MEDICAL DOCUMENTATION

REQUIRED:

1. TUBERCULIN SKIN TEST (PPD): This is required within six (6) months prior to the first day of class of the semester you enter school. Having a chest x-ray is NOT an acceptable alternative unless otherwise stated in Appendix A. Anyone with a new or previous positive PPD test, please refer to Appendix A on this form concerning Tuberculosis protocol.

Date PPD given: 5-26-15 Date results read (must be no earlier than 48 hours and no later than 72 hours): 5-28-15

Results of PPD (MUST BE DOCUMENTED IN MM - NO EXCEPTIONS!) 0 mm PLEASE, DO NOT WRITE "Negative"

Documentation / Evaluation

M.D. Printed Name

&

M.D. Signature

OR

CLINIC STAMP

REQUIRED: A copy of an immunization record with your MMRs documented will be acceptable.

2. MEASLES: Measles vaccine, Live, Attenuated IS required if born after 1957. Last dose must be since 1980.

Date 5-26-15

Type (circle):

MMR

MR

M

M.D. Printed Name

&

M.D. Signature

OR

CLINIC STAMP

*** (OPTIONAL) ***** (OPTIONAL) ***** (OPTIONAL) ***** (OPTIONAL) ***** (OPTIONAL) ***

3. Tetanus Toxoid - Date of last series or booster

4. Meningococcal Meningitis Vaccine - Date

5. Hepatitis B Series - Dates of Series

In the event this documentation is not easily obtainable, all of the above services can be provided at the Auburn University Medical Clinic for a fee

Auburn University Medical Clinic
400 Lem Morrison Drive
Auburn University, AL 36849-5349

TELEPHONE: (334) 844-4416

FAX: (334) 528-6780

E-Mail: aumcmrecords@eamc.org

Hours of Operation:

Monday - Friday 8 a.m. - 6 p.m.
Except Thursday 9 a.m. - 6 p.m.
Saturday 8 a.m. - 12 p.m.
(Hours Subject to Change)

To Make an Appointment: Please Call (334) 844-4416

WWW.AUBURN.EDU/MEDICAL

INSURANCE INFORMATION

What is the name of your insurance company? JFI Insurance Group Inc.
Subscriber# _____ Group # _____ Plan # _____
What is your insurance company's claims address _____
Who is the policy holder? _____ Gender: (circle one) M F
What is your relationship to the policy holder? _____ DOB of Policy Holder _____
Does your plan require a co-payment? _____ If so, how much? _____
What are the limits (age, full time status, etc.) on the policy for your coverage as a student? _____
Does your plan provide for "out of area" coverage for you? _____ Does your plan provide prescription benefits? _____

Please attach a legible copy of the front and back of your insurance card. If you have more than one insurance coverage, please provide both clearly stating which is primary and which is secondary. We will also need each policy holder's name, date of birth, gender and relationship to file the secondary insurance.

BILLING INFORMATION

Patient's Relationship to billing Person(s): Self ☒ Spouse ☐ Child ☐ Other ☐
Name of Billing Person(s): Eun Jung Jung
(First) (Middle) (Last)
Telephone #s: Home: () - _____ Work: () - _____ Cellular: 334-524-5093
Address: 467 Amell Lane Auburn AL 36830
(Street / P.O. Box) (City) (State) (Zip)

I hereby authorize Auburn University Medical Clinic (AUMC) to release information from my medical records as may be required or requested by my insurance company, employer, or any other persons liable to AUMC for payment of all or part of the charges pertaining to my office visits. I also authorize AUMC to act as my agent when filing insurance claims on my behalf. I directly assign to AUMC all insurance benefits and agree that any benefits payments sent to me will be promptly forwarded to AUMC. I understand that I am responsible for all charges incurred at the Auburn University Medical Clinic regardless of the degree to which my insurance covers the services rendered.

Billing Disclosure - If I have insurance, I understand balances will be filed with insurance companies under most circumstances. Items not fully paid or otherwise accounted for by an insurance company will be billed to me or my designated responsible party. After a period of time, uncollected balances may be collected through a collection agency including any additional costs related to the collection process. Balances may be placed on my registration/graduation. Any outstanding balances are my responsibility. If any checks are returned, there will be a "returned check" fee assessed for a minimum of \$30.00 and I may be referred to the "Worthless Check Unit" at the Lee County District Attorney's Office. Failure to comply by these financial policies and/or recurring instances of collection activity could result in dismissal from the practice.

I understand that some or all of my expenses at Auburn University Medical Clinic may not be covered by my health insurance. I understand and agree to pay all co-pays at the time of service. I also understand that after 60 days, any patient AND/OR insurance balance becomes my responsibility. If I choose to decline signing this document, I understand that a hold will be placed on my records for Graduation or Registration until all balances are paid in full. I agree that this agreement pertains to all visits to the Auburn University Medical Clinic. I acknowledge and understand that at all times I can receive a copy of my patient rights and responsibilities along with a privacy notice on the clinic's website and the patient portal. If I do not have internet access, I can receive a printed copy of the patient rights and responsibilities and privacy notice at the clinic.

PATIENT SIGNATURE _____

DATE 5-18-2015

Lab Order

SKIN TEST INTRADERMAL TB (Result in Labs) (86580)

EUN JUNG JUNG

Final, Reviewed

Diagnosis: Immunization due (Z23)

Ordered by Beth Pate RN on behalf of Only Nurse on 5/26/2015 (Routine)

Collected on 5/26/2015 10:06 AM

Reported on 5/28/2015 10:22 AM (LABORATORY)

Reviewed by Kirby McCard on 8/16/2016 1:37 PM

Order Note:

tbinfoc4652aa exp 1-22-2017

Test Name	Result	Units	Normal Range	Status
SKIN TEST INTRADERMAL TB	0 mm			Final, Reviewed

Procedure

MMR VACCINE SC (90707)

EUN JUNG JUNG

Final, Reviewed

Diagnosis: Immunization due (Z23)

Ordered by Beth Pate, RN on behalf of Only Nurse on 5/26/2015 (Routine)

Performed on 5/26/2015 10:06 AM

Reviewed by Beth Pate, RN on 5/26/2015
