

MEDICAL INFORMATION FORM
AUBURN UNIVERSITY
(CONFIDENTIAL)

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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: aumcmedrecords@aumc.org
Auburn University, AL 36849-5349

#408320

GENERAL INFORMATION

Name: Jung Eun Jung Social Security # 421 53 6369
Last First Middle AU User ID/GID: 2230019
Home Address: 487 Arnell Lane Student's Cell Phone: 334 524 4093
City: Auburn AL 36830 State: AL Zip: 36830
Date of Birth: 05 22 1969 Sex (circle one) M Auburn Email Address: _____
Emergency Contact - Name: Seong Hae Lee Relationship: Friend
Telephone: HOME: 334 362 6247 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!) BP 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

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

AUBURN
UNIVERSITY

Patient Information

Patient Full Name: Fun Jung Jung Date of Birth: 06/22/1969
Patient Address: 467 Arnell Lane Social Security #: 421-53-6269
City: Auburn State: AL Zip: 36830 Home Phone: (334) 246-0256
Cell Phone: (334) 524-1509 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: 7430 East Drive Phone: 334, 244, 3000
City: Montgomery State: AL Zip: 36117 Fax: 334, 244, 3896
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 Invoked 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)
- AUMC does not provide copies of records received for a
Please request these records directly from the originator.

Needs
TB
Tdap
MMR

Authorization to Release Protected Information

- *Required*** Please complete the check boxes below indicating how protected information necessarily apply to the patient's medical records.
- Release Records? Check One.
- | | |
|--|--|
| ☒ DO | ☐ DO NOT want Psychiatric Treatment Notes released. |
| ☒ DO | ☐ DO NOT want Information about Mental Health released. |
| ☒ DO | ☐ DO NOT want Information about HIV Tests & Related Information |
| ☒ DO | ☐ DO NOT want Information about Alcohol and/or Substance Abuse |
| ☒ DO | ☐ DO NOT want Information about _____ |
- Other sensitive information _____



AUBURN
MONTGOMERY

STOP 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.

Patient's Signature _____

Date: 1-12-2018

Know Your Privacy Rights
Refer to the HIPAA
PRIVACY NOTICE

Parent/Legally Recognized Representative Signature _____

Date: 1/12/2018

FAX NUMBER
(334) 528-6780

Witness _____

Date: _____

E-Mail: aumcmedrecords@eamc.org

*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: [Signature]

DATE: 1/15

Revised 11/2011