

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 1/26/16 Are you an AUM student? YES ☐ NO ☒ Student ID # _____

Name: Jonathan Brooks

Social Security Number: 603-40-0094 Birth Date: 04/13/1985

Local Phone Number: 334-447-3559 Alternate Number: _____

Local Address: 112 Edinburg Dr Box Number _____

City: Enterprise State: AL Zip Code: 36330

Permanent Address: 112 Edinburg Dr

City: Enterprise State: AL Zip Code: 36330

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

Sex (Please Circle): Male ☒ Female ☐

Primary Physician: N/A City: _____ Phone #: _____

Patient's Employer: N/A Work #: _____

Parent's or Spouse's Name (Circle which) Christi Brooks Phone #: 334-449-0440

Parent's or Spouse's Employer: Lending Bear Work #: 334-445-1216

Emergency Contact: Christi Brooks Relationship: Wife Phone #: 334-449-0440

How did you hear about the Clinic? Friend ☐ Faculty/Staff ☐ Orientation ☐ Other ☒ Job

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 _____ Name on Card _____

Policy Number _____ Group Number _____

Insurance Company Address _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Jonathan Brooks Date of Birth / /

General Consent for Treatment

I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Jonathan Brooks
Signature of Patient

01 / 26 / 2016
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient



Patient Social Security Number

003-40-0094

AUTHORIZATION FOR RELEASE OF INFORMATION FROM MEDICAL RECORD

Record Subject Brook Jonathan N 04/13/1985
(Patient's Name) Last Name First Name Middle Initial Birthday or Age

Address 112 Edinburg Dr. Enterprise, AL 334-447-3559
Street, City and State Telephone Number

I, the undersigned, hereby authorize

Jonathan Brooks

Health Care or Health Services Provider

AUM - Student Health Services

to provide from my medical record the information specified below to Occu-Med, Medical Director, 2121 West Bullard Avenue, Fresno, CA 93711 and

Name of Any Duly Authorized Representative(s)

for the purpose of evaluating health status in relation to specific essential job requirements.

I further authorize Occu-Med to provide this information from my medical record to duly authorized representatives of my employer, if requested.

The information supplied is to be restricted to _____

Medical Condition or Injury Specified and/or _____
Time Period to be Covered

and/or _____
Other Type of Information Specified

Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

This authorization shall be valid until _____
Date

Signature _____
Social Security Number _____ Date _____

or _____
Personal Representative _____ Date _____

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

Name: Jonathan Brooks Date of Birth: 04 / 13 / 1985

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 Occu-Med _____

☐ 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: 334-447-3559

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) 0900 between (time) 17:00

Signed: Jonathan Brooks Date: 1 / 26 / 2016

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 26 day of January 2016.

Print Patient Name Jonathan Brooks

Signature Jonathan Brooks

Relationship to Patient _____