

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 3/12/15 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Alonzo Brown Jr.

Social Security Number: 220-15-3315 Birth Date 10/14/1975

Local Phone Number: 334.782.0226 Alternate Number: 334.782.0358

Local Address: _____ Box Number 9345

City: Montgomery State: AL Zip Code: 36108

Permanent Address: 2453 Beecher Street

City: Montgomery State: AL Zip Code: 36108

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

Sex (Please Circle) ☒ Male ☐ Female

Primary Physician: Jernigan City: Montgomery Phone #: 334.265.6153

Patient's Employer: Strong Tower At Washington Park Church Work #: 334.782.0226

Parent's or ☒ Spouse's Name (Circle which) Antoinette Brown Phone #: 334.782.0358

Parent's or ☒ Spouse's Employer: Homemaker Work #: 334.782.0358

Emergency Contact: Antoinette Brown Relationship: Wife Phone #: 334.782.0358

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

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 _____

SERVICES CONSENT FORM

NAME: Alonzo Brown, Jr.
DATE OF BIRTH: 10/14/75

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: Alonzo Brown, Jr.
DATE: 3/12/15

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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 12 day of March 20 15.

Print Patient Name Alonzo Brown Jr.

Signature Alonzo Brown Jr.

Relationship to Patient _____

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

Name: Alonzo Brown Jr. Date of Birth: 10 / 14 / 1975

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: 334.782.0226

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: Alonzo Brown Jr. Date: 3 / 12 / 15