



Alabama Department of Public Health

Bureau of Clinical Laboratories

Montgomery Laboratory
P.O. Box 244018
Montgomery, AL 36124-4018
(334) 260-3400

Mobile Laboratory
757 Museum Drive
Mobile, AL 36608
(251) 344-6049

www.adph.org/bcl

Report To PRIMARY CONTACT
AUM NURSING CARE CENTER
IRMA B. MOORE HALL RM.102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023
USA

Patient Information

Name	KIA HOLLOWAY 2525 GREENVILLE ST MONTGOMERY, AL 36107 (334)590-6228	SSN	559-19-7657
		Date of Birth	10/2/1966
		Gender	Female
		Race	Black or African American
		Ethnicity	Not Hispanic
County of Residence	MONTGOMERY	LIMS Patient ID	X975129

Sample Information

Sample ID (MRN)	HOLLOWAY	Date Collected	2/3/2014
Lab ID	M1402009910-01	Date Received	2/11/2014 10:18 AM
Chain of Custody		Date Reported	2/13/2014 05:15 PM
Specimen Source	Urine	Performing Facility	Montgomery Lab

NPI Provider's First Name?

NPI Provider's Last Name?

Bill To

Comments

The performance of Oral and Rectal Swabs are not FDA approved, but have been validated by the BCL on specimens for Chlamydia Trachomatis and Neisseria Gonorrhoeae testing from patients attending STD and Adult Health Clinics. The Oral and Rectal Swabs have NOT been validated by the BCL for Trichomonas Vaginalis testing. The Aptima Trichomonas Vaginalis Assay has not been approved for testing on male patients by the FDA, but has been validated by the BCL on specimens from male patients attending STD and Adult Health Clinics.

Test/Observation	Result	Method / Ref Range
-- SEROLOGY CT-GC -- Chlamydia Trachomatis	NONREACTIVE	Gen-probe APTIMA Combo 2 Assay
Neisseria Gonorrhoeae	NONREACTIVE	Gen-probe APTIMA Combo 2 Assay
-- SEROLOGY TV -- Trichomonas Vaginalis	NONREACTIVE	Gen-probe APTIMA Assay



SOLSTAS
LAB PARTNERS

2732 7th Ave South
Birmingham, AL 35233
Phone: 205-313-1240
Fax: 205-313-1250

AUM NURSING CARE CENTER
7461 EAST DRIVE
MONTGOMERY, AL 36117

Patient Name HOLLOWAY, KIA			Requesting Physician: FUENTES, MARYLUZ
Sex/Species: FEMALE	Date of Birth: 10/02/1966	Age: 47	Accession: E214812
Patient Phone:	Patient ID #: HOLLOWAYKIA034	Med. Rec. #:	Requisition: 02/03/2014 13:45
			Collected: 02/04/2014 06:51
			Reported:

REQUEST	RESULT	UNITS	NORMALS	TEST LOC
TSH (THIRD GENERATION)	1.406	uIU/mL	0.35-4.50	BHAM
CBC with DIFFERENTIAL				BHAM
WHITE BLOOD CELL COUNT	6.1	K/uL	3.5-11.0	
RED BLOOD CELL COUNT	4.15	mil/uL	3.70-5.10	
HEMOGLOBIN	12.4	g/dL	11.4-15.0	
HEMATOCRIT	37.3	%	33.0-45.0	
MCV	89.9	fL	80-98	
MCH	29.9	pg	26.0-34.0	
MCHC	33.2	g/dL	32.0-36.0	
RDW	13.6	%	11.0-15.4	
PLATELET COUNT	329	K/uL	150-400	
SEGMENTED NEUTROPHILS	47.3	%	35.0-75.0	
LYMPHOCYTES	42.7	%	17.0-43.0	
MONOCYTES	7.3	%	0.0-12.0	
EOSINOPHILS	2.4	%	0.0-6.0	
BASOPHILS	0.3	%	0.0-2.0	

FINAL REPORT

Testing Locations:

BHAM SOUTHERN DIAGNOSTIC LABORATORIES - 2732 7TH AVENUE SOUTH BIRMINGHAM, AL 35233 205-313-1240 CLIA #: 01D1015388

AUM NURSING CARE CENTER

URINE DIPSTICK RESULTS

NAME Kia Holloway DATE 2/3/14

BIRTHDATE 10/2/66 LMP _____

Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
pH	5	6	7	8	9		
Leukocytes	Neg.	Trace	+1	+2			
Nitrite	Neg.	Pos.					
Protein	Neg.	Trace	+1(30)	+2(100)	+3(500)	(mg/dl)	
Glucose	Normal	50	100	250	500	1000	(mg/dl)
Ketones	Neg.	+1(sml)	+2(mod)	+3(lg)			
Urobilinogen	Normal	1	4	8	12	(mg/dl)	
Bilirubin	Neg.	+1	+2	+3			
Blood	Neg.	5-10	50	250	ery/l		

Staff Signature Brittany Meyer RN

DMA_

WHOSE Records to be Disclosed

Form Approved
OMB No. 0963-0023

NAME (First, Middle, Last, Suffix)

Kia Holloway

SSN

559-19-7657

Birthday
(mm/dd/yy)

10/02/66

AUTHORIZATION TO DISCLOSE INFORMATION TO
THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW **

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

- All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
 - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Sickle cell anemia
 - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
 - Gene-related impairments (including genetic test results)
- Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
- Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
- Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

AUBURN MONTGOMERY STUDENT
HEALTH CENTER
POST OFFICE BOX 244023
MONTGOMERY AL 36124-4023

1/2014-3/2014

TO WHOM

The Social Security Administration and to the State agency authorized to process my case (usually called "disability determination services"), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE

Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am capable of managing benefits ONLY (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN  Electronically Signed By:
Kia HollowayIF not signed by subject of disclosure, specify basis for authority to sign
☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)

(Parent/guardian/personal representative sign here if two signatures required by State law)

Date Signed

10/24/13

Street Address

2525 Greenville St

Phone Number (with area code)

205-200-5113

City

Montgomery

State

AL

ZIP

36107

WITNESS I know the person signing this form or am satisfied of this person's identity:

SIGN 

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN 

Phone Number (or Address)

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Form SSA-827 (11-2012) of (11-2012) Use 4-2009 and Later Editions Until Supply is Exhausted

Page 1 of 2

**Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"**

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(i) and 1631(e)(7)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(1)(i), 1383(d)(i) and 1383(e)(1)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled: Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090; Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 60-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.