



**AUBURN UNIVERSITY
AT MONTGOMERY**

STUDENT HEALTH SERVICES

**Patient Information Update Form
(Please Print Legibly)**

Date: 11/6/19 Are you an AUM Student? Yes ☐ No ☒ Student Number: _____

Name: Amanda Brasington Preferred: Amanda Birthdate: 3/23/85

Phone Number: 334-312-4907 Email: abrasing@aum.edu

Local Mailing Address: 9065 Black Cherry Trl Box or APT#: _____

City: Pike Road State: AL Zip Code: 36064

Marital Status: Single ☐ Married ☒ Divorced ☐ Widowed ☐ Other: _____

Primary Physician: Dr. Herndon City: Montgomery Phone #: 334-396-9100

Emergency Contact: Leon Brasington Jr. Relationship: Husband Phone#: 334-850-9493

Insurance Information

Do you have health insurance? Yes ☒ No ☐

If Yes, please give your card to the front desk in order for a copy to be made for your chart.

Insurance Company: BC/BS Name of Policy Holder: Leon R Brasington Jr.

Policy or Contract Number: PPA 871929902 Group Number: 44947

Insurance Company's Address: 450 Riverchase Pkwy East
Birmingham, AL 35244

Medical History

Do you have any new allergies, medical conditions, or procedures: (Include hospitalization, illnesses, and surgeries)

None

Are you taking any medications regularly at the present time (including allergy injections, antidepressants, contraceptives, over-the-counter drugs, etc.)? Yes ☒ No ☐

If yes, please list IUD

Preferred Pharmacy and Phone number: CVS at Pike Road 334-277-1153

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

Name: Amanda Brasington Date of Birth 3/23/85

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: Leon Brasington Jr.

☐ Child(ren): _____

☒ Other: Karen Montz (Mother)

☐ 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)-312-4907

If unable to reach me:

☒ you may leave me a detailed message

☐ please leave a message asking me to return your call

☐ other: _____

The best time to reach me is (day or days) Any time between _____ and _____ times.

Signed: Amanda M. Brasington

Date: 11/6/19

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Amanda Brasington Date of Birth: 3 / 23 / 85
Day Month Year

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 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.

Amanda M. Brasington

Signature of Patient

3 / 23 / 85
Day Month Year
Date of Signature

Signature of Legal Representative (if patient is unable to sign)

Relationship to Patient

See Back of Form

AUM Student Health Services

PATIENT HIPPAA 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 (HIPPA). 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 involve 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 HIPPA. 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 with 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 6th day of November 20 19.
(day) (month) (last two digits of the year)

Print Patient's Name: Amanda M. Brasington

Signature: Amanda M. Brasington

Relationship to Patient (if you are the patient, write "self"): self