**Past Medical History:** Please put a check (✓) next to all items that apply to you:

<table>
<thead>
<tr>
<th>Allergic Rhinitis (Hayfever)</th>
<th>Gastroparesis</th>
<th>Prostate Enlargement (BPH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>Glaucoma</td>
<td>Psoriasis</td>
</tr>
<tr>
<td>Anxiety / Nerves / Nervous Breakdown</td>
<td>Gout</td>
<td>Psoriatic Arthritis</td>
</tr>
<tr>
<td>Asthma</td>
<td>Headaches (Type: ______)</td>
<td>Sexual dysfunction</td>
</tr>
<tr>
<td>Arthritis (Type: _____________)</td>
<td>Heart attack (MI)</td>
<td>Stroke</td>
</tr>
<tr>
<td>Bladder / Kidney infections</td>
<td>Heart disease (CAD)</td>
<td>Sleep Apnea</td>
</tr>
<tr>
<td>Cancer (Type: ________________)</td>
<td>Heart Failure (CHF)</td>
<td>Thyroid disorder</td>
</tr>
<tr>
<td>Cataracts</td>
<td>Heart valve replacement</td>
<td>Ulcer (PUD)</td>
</tr>
<tr>
<td>Chest Pain (angina)</td>
<td>Heartburn</td>
<td>Urinary frequency</td>
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<tr>
<td>Chronic Obstructive Lung Disease (COPD)</td>
<td>High blood Pressure (HTN)</td>
<td>Urinary hesitancy</td>
</tr>
<tr>
<td>Chronic Pain (Type: ___________)</td>
<td>High cholesterol</td>
<td>Weakness/ Tired</td>
</tr>
<tr>
<td>Constipation</td>
<td>High triglycerides</td>
<td>Other: ____________________</td>
</tr>
<tr>
<td>Depression</td>
<td>Incontinence</td>
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<tr>
<td>Diabetes / High Blood Sugar</td>
<td>Insomnia (Difficulty Sleeping)</td>
<td>Other: ____________________</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Irritable Bowel (IBS)</td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td>Menopause</td>
<td>Other: ____________________</td>
</tr>
</tbody>
</table>
Allergies: ____________________________

Additional Information Concerning Your Health History: ___________________________

Past Surgical History / Hospitalizations:

Have you ever needed to go to the emergency room for care or been admitted to the hospital? Have you ever had outpatient or inpatient surgery? If so, how old were you when this happened? What was the reason for this care?

<table>
<thead>
<tr>
<th>Your Age at Time of Care</th>
<th>Reason for ED Visit of Hospitalization – OR- Type of Surgery</th>
</tr>
</thead>
<tbody>
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</table>

Family History (check all that apply):

- Obesity
- Diabetes
- High Blood Pressure
- High Cholesterol
- Heart Disease
- Cancer

Social History:

- **Tobacco:** Do you currently or have you ever used any type of tobacco (cigars, cigarettes, chewing tobacco, snuff, etc.)? _______
- If yes, what type of tobacco?___________________
  At what age did you start? _____________
  How long have you or did you use these products? _____________
  How much did you or do you use per day on average? _____________

- **Alcohol:** Do you consume alcoholic beverages?_________
  If yes, what type of alcohol do you drink?___________________
  How often do you drink?___________________
• How much do you typically drink each time? __________________________
  Do you have a history of alcohol abuse? __________________________

• **Drugs:**  Do you use recreational drugs (marijuana, cocaine, etc.)? __________
  If so, what type? __________________________

• **Caffeine:**  Do you ingest caffeine (colas, tea, coffee, chocolate, etc.)? __________
  How many servings of caffeinated foods or beverages do you ingest every day on average? _______________

• **Diet:**  Do you follow any special or restrictive diets (low-salt, low-fat, low-carb, diabetic, high protein, etc.)? __________________________

• **Exercise:**  Do exercise regularly? __________
  If so, describe your exercise program (types of activities, frequency, length, etc.)
  ___________________________________________________________________
  ___________________________________________________________________

Do you take any prescription or over the counter medications? If so, please provide the following information:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose (milligrams, units, etc.)</th>
<th>When do you take it? (time of day)</th>
<th>When did you start taking this medication?</th>
<th>What is this medication for?</th>
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AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR SERVICE. I hereby consent to the services provided by the State Employees’ Insurance Board Healthcare Center (SEIB HCC). I understand that these services may include limited physical assessment, lab testing and non-invasive testing along with cognitive services. ______________(initial)

PRIVACY POLICY. I acknowledge having received the SEIB HCC’s, “Notice of Privacy Policies”. My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explain in the Policy. I understand that I may revoke my consent for release of my health care information in writing, except to the extent the SEIB HCC has already made disclosures with my prior consent. ______________(initial)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.
I authorize use and disclosure of my personal health information for the purposes of diagnosis or treatment, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the SEIB HCC. I authorize the release of any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the SEIB HCC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. __________(initial)

______________________________     __________________       __________
Patient of Authorized Person Signature        Relationship    Date
CONTACT INFORMATION FORM
Patient Request for
Confidential Communication of Protected Health Information

I, ___________________________________________ (patient name), do hereby request that my pharmacist provider communicate with me in a confidential manner by using the following methods of communication and contact information when wishing to reach me.

☐ If contacting me in writing:
   Street Address/P.O. Box:

   City, State and Zip Code:

☐ If contacting me by telephone:
   ➢ Yes / No Talk to me only
   ➢ Yes / No May leave message with person answering phone
   ➢ Yes / No May leave message on answering machine
   Telephone Number: Work / Home

☐ If contacting me by telephone, and I am not available please call:
   Telephone Number: Work / Home

☐ If contacting me electronically:
   E-mail address:

Please indicate which contact method you prefer

Understanding and Acknowledgement
1. I acknowledge that by requesting confidential communications I may prevent the use and disclosure of my PHI to family members, friends, caregivers, and others that might be for my benefit.
2. I understand that I am responsible if the contact information provided above is incorrect, or if it is later changed and I fail to report the change.

____________________________________________________ ______ ___________
Signature of Person Submitting Request    Date
Your Health Information Rights

You have the following rights with respect to PHI about you:

Obtain a paper copy of the Notice upon request. You may request a copy of the Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. To obtain a paper copy, contact the Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of PHI about you by sending a written request to Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849. We are not required to agree to those restrictions.

Inspect and obtain a copy of PHI. You have the right to access and copy PHI about you contained in a designated record set for as long as Pharmacy Health Services maintains the PHI. The designated record set usually will include prescription and billing records. To inspect or copy PHI about you, you must send a written request to Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849. We may charge you a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to PHI about you, you may request that the denial be reviewed.

Request an amendment of PHI. If you feel that PHI we maintain about you is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the PHI. To request an amendment, you must send a written request to Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849. You must include a reason that supports your request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give a rebuttal to your statement.

Receive an accounting of disclosures of PHI. You have the right to receive an accounting of the disclosures we have made of PHI about you after April 14, 2003, for most purposes other than treatment, payment, or health care operations. The accounting will exclude certain disclosures, such as disclosures made directly to you, disclosures you authorize, disclosures to friends or family members involved in your care, and disclosures for notification purposes. The right to receive an accounting is subject to certain exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849. Your request must specify the time period, but may not be longer than six years. The first accounting you request within a 12 month period will be provided free of charge, but you may be charged for the cost of providing additional accountings. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.

Request communications of PHI by alternative means or at alternative locations. For instance, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of PHI about you, you must submit a request in writing to Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849. Your request must state how or where you would like to be contacted. We will accommodate all reasonable requests.

Receive written notification of a breach of your unsecured PHI. You have the right to receive written notification of a breach where your unsecured PHI has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and the breach compromises the security and privacy of your PHI. Unless specified in writing by you to receive this breach notification by electronic mail, we will provide this notification by first-class mail or, if necessary, by such other substituted forms of communication allowable under the law.

Examples of How We May Use and Disclose PHI

The following are descriptions and examples of ways we use and disclose PHI:

We will use PHI for treatment. Example: Information obtained by the pharmacist will be used to dispense prescription medications to you. We will document in your record information related to the medications dispensed to you and services provided to you.

We will use PHI for payment. Example: We will contact your insurer or pharmacy benefit manager to determine whether it will pay for your prescription and the amount of your copayment. We will bill you or a third-party payor for the cost of prescription
medications dispensed to you. The information on or accompanying the bill may include information that identifies you, as well as the prescriptions you are taking.

We will use PHI for health care operations. Example: PHARMACY HEALTH SERVICES may use information in your health record to monitor the performance of the pharmacists providing treatment to you. This information will be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

We are likely to use or disclose PHI for the following purposes:

Business associates: There are some services provided by us through contracts with business associates. A few examples include:
- Pharmacy Health Services may contract with a firm to perform quality assurance surveys for the purpose of continuous quality improvement.
- Pharmacy Health Services may contract with software vendors to supply, maintain, and upgrade computer software used for dispensing and billing.

When these services are contracted for, we may disclose PHI about you to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payor for services rendered. To protect PHI about you, we require the business associate to appropriately safeguard the PHI.

Communication with individuals involved in your care or payment for your care: Health professionals such as pharmacists, using their professional judgment, may disclose to a family member, other relative, close personal friend or any person you identify, PHI relevant to that person’s involvement in your care or payment related to your care.

Health-related communications: We may contact you to provide refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker’s compensation: We may disclose PHI about you as authorized by and as necessary to comply with laws relating to worker’s compensation or similar programs established by law.

Public health: As required by law, we may disclose PHI about you to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose PHI about you for law enforcement purposes as required by law or in response to a valid subpoena or other legal process.

As required by law: We must disclose PHI about you when required to do so by law.

Health oversight activities: We may disclose PHI about you to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for our licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and administrative proceedings: If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.

We are permitted to use or disclose PHI about you for the following purposes:

Research: We may disclose PHI about you to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, medical examiners, and funeral directors: We may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to carry out their duties.

Organ or tissue procurement organizations: Consistent with applicable law, we may disclose PHI about you to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Fundraising: We may contact you as part of a fundraising effort but you will be provided with an opportunity to opt out of any future such communications.

Notification: We may use or disclose PHI about you to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and your general condition.

Correctional institution: If you are or become an inmate of a correctional institution, we may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

To avert a serious threat to health or safety: We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and veterans: If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate military authority.

National security and intelligence activities: We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective services for the President and others: We may disclose PHI about you to authorized federal official so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Victims of abuse, neglect, or domestic violence: We may disclose PHI about you to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else or the law enforcement or public official that is to receive the report represents that it is necessary and will not be used against you.

Other Uses and Disclosures of PHI
Pharmacy Health Services will obtain your written authorization before using or disclosing PHI about you for purposes other than those provided for above or as otherwise permitted or required by law. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing PHI about you, except to the extent that we have already taken action in reliance on the authorization.

For More Information or to Report a Problem
If you have questions or would like additional information about Pharmacy Health Services’ privacy practices, you may contact Pharmacy Health Services Director at 2155 Walker Building, Auburn, AL 36849; (334) 844-4099. If you believe your privacy rights have been violated, you can file a complaint with Pharmacy Health Services Director or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Effective Date
This Notice is effective as of February 17, 2010.