AUM | AUBURN UNIVERSITY AT MONTGOMERY
STUDENT HEALTH SERVICES

P.O. Box 244023
Montgomery, AL 36124
Phone: 334-244-3281
Fax: 334-244-3396

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Information

Student Number: _____

Name: _____ Date of Birth: ____/____/_____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____ Email: _____

Please select one of the following:

☐ **Release** information **FROM Auburn University at Montgomery Student Health Services** to an AUM department/outside medical facility/person (Circle one)

☐ **Release** information from an AUM department/outside medical facility/person (Circle one) **TO Auburn University at Montgomery Student Health Services**

Outside Medical Facility/ AUM Department/Person

Name: _____ Date of Birth: ____/____/_____

Address: _____ Phone: _____ Fax: _____

City: _____ State: _____ Zip: _____ Email: _____

Please select one of the following:

☐ Fax Records ☐ Mail Records ☐ Hold Records for Patient Pickup

Type(s) of Records Requested:

☐ **Immunizations ONLY**: please specify (if all, put ALL)_____
☐ **Radiology Report**
☐ **Lab Results**
☐ **General summary of treatment issues, progress, current functioning**
☐ **Other:** please specify_____

This consent may be needed at any time by the patient/client, but ending the consent will not cancel any actions that have already taken as allowed by this form. Unless the client wishes to cancel this consent at an earlier time, it will automatically stop upon the date and/or condition indicated below.

Date: _____ Event/Consent: _____

It is understood that the duration of this consent will not be longer than necessary and reasonable to carry out the purpose for which it is given.

_____ _____ _____
Patient Name or Authorized Representative **(Please Print)** Patient's **Signature** or Authorized Representative **Date**

_____ _____ _____
Last 4 of Patient's Social Security # Witness Signature **(REQUIRED)** **Date**