

* * * Communication Result Report (Mar. 3. 2025 4:19PM) * * *

1) AUM Warhawk Health Svcs.
2)

Date/Time: Mar. 3. 2025 4:17PM

File No. Mode	Destination	Pg(s)	Result	Page Not Sent
0054 Memory TX	92771454	P. 1	OK	

Reason for error
 E. 1) Hang up or line fail
 E. 3) No answer
 E. 5) Exceeded max. E-mail size

E. 2) Busy
 E. 4) No facsimile connection
 E. 6) Destination does not support IP-Fax

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:	Lindsey Barten	Date of Birth:	8/8/82
Address:	2020 Red Hawk Rd	Phone Number:	(334) 744-7180
City:	Prattville	State:	AL Zip: 36067 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:	East Montgomery Imaging	Date of Birth:	/ /
Address:		Phone:	Fax: 277-1741
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 MRI/MRA from 9/27/25
- ☐ 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.

Lindsey Barten
 Patient Name or Authorizing Representative (Please Print)

Signature
 Last 4 of Patient's Social Security #

Lindsey Barten
 Patient Signature or Authorized Representative

Signature
 Witness Signature (REQUIRED)

3/3/25
 Date

Signature
 Date

8/2/24



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: Lindsey Barten Date of Birth: 8/8/82
Address: 2026 Red Hawk Rd Phone Number: (334) 714-7186
City: Prattville State: AL Zip: 36067 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: East Montgomery Imaging Date of Birth: ____/____/____
Address: _____ Phone: _____ Fax: 277-1781
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 MRI/MRA team 2/27/25
- ☐ 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.

Lindsey Barten
Patient Name or Authorized Representative (Please Print)

5697
Last 4 of Patient's Social Security #

Lindsey Barten
Patient's Signature or Authorized Representative

MB RN
Witness Signature (REQUIRED)

3/3/25
Date

3/3/25
Date