



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: SCOTT PARSONS Date of Birth: 2/5/1973
Address: 2023 Ellen St Phone Number: 334.740.9584
City: Montgomery State: AL Zip: 36106 Email: parsonsw@gmail.com

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: GARDENIA Date of Birth: / /
Address: 7479 Halcyan Pointe Dr. Phone: 334-954-0011 Fax: 649-6399
City: Montgomery State: AL Zip: 36117 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.

SCOTT W. PARSONS
Patient Name or Authorized Representative (Please Print)

[Signature]
Patient's Signature or Authorized Representative

7.13.22
Date

2412
Last 4 of Patient's Social Security #

[Signature]
Witness Signature (REQUIRED)

9/13/2022
Date