

* * * Communication Result Report (May. 31. 2024 9:14AM) * * *

1) AUM Warhawk Health Svcs.
2)

Date/Time: May. 31. 2024 9:07AM

File	No. Mode	Destination	Pg(s)	Result	Page Not Sent
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Reason for error

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P.O Box 244023
Montgomery, AL 36124
Phone: 334-244-3281
Fax: 344-244-3396



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

Attn: Shelley Byrd
To: Jackson Family Medicine From: Doretha
Fax: 293-8154 Pages: 16
Phone: 240-2334 Date: 5/31/24
Re: Medical Records

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:

Important: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability Act (HIPPA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.



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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: Pepper Martin Date of Birth: 12/03/1975
Address: 916 Thomas Court Phone Number: 334-294-4471
City: Montgomery State: AL Zip: 36108 Email: pmartin@aum.edu

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

SEND TO

Outside Medical Facility/ AUM Department/ Person

Name: Shelley Bryd CRNP Date of Birth: / /
Address: 1758 Park Pl Phone: 240-2334 Fax:
City: Montgomery State: AL Zip: 36106 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 CT- All records 5/21/24 - 5/22/24

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: 5/29/2024 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.

Pepper Martin
Patient Name or Authorized Representative (Please Print)

8393
Last 4 of Patient's Social Security #

Ryann M. Martin
Patient's Signature or Authorized Representative

Chad Magette
Witness Signature (REQUIRED)

5/29/2024
Date

5/29/24
Date