



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: Barnett Waldrott Date of Birth: 1/12/15
 Address: 2158 Carol Ln Phone Number: 334-788-5439
 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: Prattville Imaging Center 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 MRI results
- ☐ 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.

Joshua Waldrott
 Patient Name or Authorized Representative (Please Print)

[Signature]
 Patient's Signature or Authorized Representative

4-15-26
 Date

6606
 Last 4 of Patient's Social Security #

[Signature]
 Witness Signature (REQUIRED)

4/15/2026
 Date