



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: Barrett Waldorf Date of Birth: 01/12/2019
Address: 2159 County Rd. 61 Phone Number: 334-940-8712
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: Elmore Community Hospital ER Date of Birth:
Address: 500 Hospital Dr. Phone: (334) 507-4311 Fax: (334) 507-5919
City: Netumpka State: AL Zip: 36092 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 all notes/reports from ER visit on 7/28/2024

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.

Miranda Bicknell (mom)
Patient Name or Authorized Representative (Please Print)

www
Last 4 of Patient's Social Security #

[Signature]
Patient's Signature or Authorized Representative

[Signature]
Witness Signature (REQUIRED)

7/30/2024
Date

7/30/24
Date



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Name: <u>Barrett Waldruff</u>	Date of Birth: <u>01/12/2019</u>
Address: <u>2159 County Rd. 61</u>	Phone Number: <u>334-546-8712</u>
City: <u>Prattville</u> State: <u>AL</u> Zip: <u>36067</u>	Email: _____

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Outside Medical Facility/ AUM Department/Person

Name: <u>Baptist South ER</u>	Date of Birth: <u> </u> / <u> </u> / <u> </u>
Address: _____	Phone: _____ Fax: _____
City: _____ State: _____ Zip: _____	Email: _____

Please select one of the following:

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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 all ER notes/reports from ER visit on 7/28/2024/7/29/2024

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Miranda Bicknell (mom)
Patient Name or Authorized Representative (Please Print)

6606
Last 4 of Patient's Social Security #

[Signature]
Patient's Signature or Authorized Representative

[Signature]
Witness Signature (REQUIRED)

7/30/2024
Date

7/30/24
Date



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Outside Medical Facility/ AUM Department/Person

Name: <u>Children's Hospital Birmingham</u>	Date of Birth: <u> </u> / <u> </u> / <u> </u>
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 all notes/reports from ER visit + admission to floor + discharge records on 7/29/24 - 7/30/24

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Miranda Ricknell (mom)
Patient Name or Authorized Representative (Please Print)

[Signature]
Patient's Signature or Authorized Representative

Date

6606
Last 4 of Patient's Social Security #

Witness Signature (REQUIRED)

Date