

TRANSMISSION VERIFICATION REPORT

TIME : 08/03/2021 15:07
NAME : AUM
FAX : 3342443396
TEL :
SER.# : BR0D8J659256

DATE, TIME	08/03 15:06
FAX NO./NAME	92771781
DURATION	00:00:48
PAGE(S)	01
RESULT	OK
MODE	STANDARD

Patient Release of Medical Records Form

Patient's Name: Jalyn Bowen request and give my permission to release my

Medical records for the following information labs, progress notes, imaging,

from the following medical facility or office Bmcs ER

The Medical Records as listed above are to be released to:

Auburn University Student Health Center

P.O. Box 244023

Montgomery, AL 36124

Phone Number (334) 244-3281

Fax Number (334) 244-3396

Patient Signature Authorization

I give permission to the representatives to the Auburn University Student Health Center to obtain my medical records. I understand that verbal exchanges between the individuals or agencies may be ongoing. This consent is valid as long as I am a patient of the Auburn University Student Health Center or until I revoke my permission in writing.

Jalyn Bowen
Signature of Patient

7/28/21
Date

Date of birth 04/22/99

SS# 1475

Full Printed Name of Patient Jalyn Bowen

Address 3031 Fieldcrest Drive

Montgomery, AL 36106

Witness David Marzetti

Date 7-28-21