

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



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

AUTHORIZATION TO RELEASE/MEDICAL INFORMATION

Patient Information

Name: Maria F. Breitman Date of Birth: 12/01/1983
Address: 117 St. Martin Dr. Phone Number: 334-283-8177
City: Rainbow City State: AL Zip: 35906 Email: mbreitma@evm.edu

Please select one of the following:

- ☒ Release information **FROM Auburn University at Montgomery Student Health Services** to an AUM department/outside medical facility/outside medical facility/person (Circle one)
- ☐ Obtain 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: Dr. Scarbrough Date of Birth: / /
Address: 1026 Goodyear Ave. Phone: 256-492-8256 Fax:
City: Gadsden State: AL Zip: 35906 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 RECORDS

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.

Maria Floriano Breitman
Patient Name or Authorized Representative (Please Print)

Debra Muzette
Witness Signature (REQUIRED)

[Signature]
Patient's Signature or Authorized Representative

10-28-21
Date

10/28/2021
Date