



10-09-'25 08:34 FROM- EMIC 334-277-1781

Oct. 9, 2025 8:52AM AUM Warhawk Health Svcs.

AUM

**AUBURN UNIVERSITY
AT MONTGOMERY**

STUDENT HEALTH SERVICES

T-061 P0001/0002 F-866

No. 0894 P. 2
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: <u>Miranda Bicknell</u>	Date of Birth: <u>3/25/1988</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: <u>P.Bicknell@auburn.edu</u>

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: <u>EMIC</u>	Date of Birth: ____/____/____
Address: _____	Phone: _____ Fax: <u>277-1781</u>
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
- ☒ Others: please specify CT Hip x-ray

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
Patient Name or Authorized Representative (Please Print)

4491
Last 4 of Patient's Social Security #

[Signature]
Patient's Signature or Authorized Representative

[Signature]
Witness Signature (REQUIRED)

10/7/2025
Date

10/7/25
Date