

TRANSMISSION VERIFICATION REPORT

TIME : 11/04/2021 11:22
NAME : AUM
FAX : 3342443396
TEL :
SER.# : BROD8J659256

DATE, TIME
FAX NO./NAME
DURATION
PAGE(S)
RESULT
MODE

11/04 11:20
9133474781419741319
00:01:06
03
OK
STANDARD



MEDICAL CLINIC

400 Lem Morrison Drive
Auburn University, AL 36849
Phone: 334-844-4416 Fax: 334-528-6780
aumcmrecords@eamc.org

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL INFORMATION

Patient information

Name: GRAY Devonna Marica
Last First Middle
Address: 5621 Calmar Dr. # C
City: Montgomery State: AL Zip: 36116

Date of Birth: 3/25/1961
Cell Phone: (518) 364-4394
Email: Devonna.gray1030@gmail.com

Please select one of the following:

- ☐ Release information FROM Auburn University Medical Clinic to an outside facility/clinic/person
☒ Obtain information from outside facility/clinic/person TO Auburn University Medical Clinic

Purpose of Request:

- ☐ New Patient Request ☐ Legal ☐ Personal ☐ Transfer out ☒ Coordination of Care

Outside Clinic/Facility Information

Name/ Facility: Baptist infusion Center
Address: _____
City: _____ State: _____ Zip: _____

Phone: (334) 747-4450
Fax: (334) 717-8141

Please select one of the following:

- ☒ Fax Records ☐ Mail Records ☐ Hold Records for Patient Pickup

Information Type(s):

- ☐ Immunizations ONLY: please specify (if all, put ALL) _____
Date Range of Records Request 8/1/21 to 9/10/21
☒ Clinic Notes
☒ Lab Reports
☒ Radiology Report/ CD (please note there is a \$16 charge for CD picked up from AU Med Clinic)
☐ Other: please specify _____

There is a fee of \$1.00 per page for the first 25 pages and \$.50 per page for each additional page after 25 for any records picked up by the patient from the AU Medical Clinic.

There is no fee to send records from the AU Medical Clinic to another clinic/physician.

PLEASE ALLOW AUMC RECORDS DEPARTMENT 3 BUSINESS DAYS TO COMPLETE YOUR REQUEST

AUMC does not provide copies of records received from another physician or institution. Please request these records directly from the original healthcare provider.

Signature (Patient's or Patient's Authorized Representative)

Date

Witness Signature (REQUIRED)

Date

This authorization is valid for 90 days unless you specify otherwise. You may revoke this authorization at any time by providing a written statement to the medical record department except to the extent that AUMC has already completed the action.



MEDICAL CLINIC

400 Lem Morrison Drive
Auburn University, AL 36849
Phone: 334-844-4416 Fax: 334-528-6780
aumcmedrecords@eamc.org

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL INFORMATION

Patient information

Name: Gray Devonna Maria Date of Birth: 3/25/1961
Last First Middle
Address: 5621 Calmar DR. #C Cell Phone: (518) 364-4394
City: Montgomery State: AL Zip: 36116 Email: Devonna.gray163@gmail.com

Please select one of the following:

- ☐ Release information FROM Auburn University Medical Clinic to an outside facility/clinic/person
☒ Obtain information from outside facility/clinic/person TO Auburn University Medical Clinic

Purpose of Request:

- ☐ New Patient Request ☐ Legal ☐ Personal ☐ Transfer out ☒ Coordination of Care

Outside Clinic/Facility Information

Name/ Facility: Baptist Medical Center East Phone: ()
Address: Montgomery State: AL Zip: 36117 Fax: (334) 717-8141

Please select one of the following:

- ☒ Fax Records ☐ Mail Records ☐ Hold Records for Patient Pickup

Information Type(s):

- ☐ Immunizations ONLY: please specify (if all, put ALL) _____

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