

* * * Communication Result Report (Jun. 15. 2023 5:08PM) * * *

1) AJM Warhawk Health Svcs.
2)

Date/Time: Jun. 15. 2023 4:37PM

File No. Mode	Destination	Pg(s)	Result	Page Not Sent
4394 Memory TX	97477580	P. 3	OK	

Reason for error
 E. 1) Hang up or line fail
 E. 3) No answer
 E. 5) Exceeded max. E-mail size

E. 2) Busy
 E. 4) No facsimile connection
 E. 6) Destination does not support IP Fax

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



AUBURN UNIVERSITY
 AT MONTGOMERY

WARHAWK HEALTH SERVICES

Attn: Monique / Medical Records
 To: LAPP From: Doedra
 Fax: 747-7580 Pages: 3
 Phone: 747-7575 Date: 6/15/23
 Re: Medical Records Request
☐ Urgent ☐ For Review ☐ Please Comment ☒ Please Reply ☐ Please Recycle
 Comments: Please fax medical records back to 334-244-3396

Important: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

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Phone: 334-244-3281
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**AUBURN UNIVERSITY
AT MONTGOMERY**

WARHAWK HEALTH SERVICES

Attn: Monique / Medical Records

To: UAB

From: Daedra

Fax: 747-7580

Pages: 3

Phone: 747-7575

Date: 6/15/23

Re: Medical Records Request

☐ Urgent ☐ For Review ☐ Please Comment ☒ Please Reply ☐ Please Recycle

Comments:

Please fax medical records back
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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: <u>DAVID M. WALKER</u>	Date of Birth: <u>05/28/1960</u>
Address: <u>2322 COLLEGE ST.</u>	Phone Number: <u>251-366-0029</u>
City: <u>MONTGOMERY</u> State: <u>AL</u> Zip: <u>36106</u>	Email: <u>David.Walker@Aum.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>PATEL - BAPTIST MEDICAL</u>	Date of Birth: <u>05/28/1960</u>
Address: <u>2055 E. SOUTH BLVD</u>	Phone: <u>334-747-7575</u> Fax: <u>747-7580</u>
City: <u>MONTGOMERY</u> State: <u>AL</u> Zip: <u>36116</u>	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 MRI SCANS; entire record

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.

DAVID M. WALKER
Patient Name or Authorized Representative (Please Print)

8267
Last 4 of Patient's Social Security #

[Signature]
Patient's Signature or Authorized Representative

[Signature]
Witness Signature (REQUIRED)

1/9/2023
Date

1/9/23
Date



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: 5106
Name: David Walker Date of Birth: 5/28/1960
Address: 2322 COLLEGE ST. Phone Number: 251-366-0029
City: MONTGOMERY State: AL Zip: 36106 Email: David.Walker@aum.edu

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: LESLIE HARRIS -UAB Internal Date of Birth: 1/1/334
Address: _____ Phone: 747-7575 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 _____

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DAVID M. WALKER
Patient Name or Authorized Representative (Please Print)

8267
Last 4 of Patient's Social Security #

[Signature]
Patient's Signature or Authorized Representative

[Signature]
Witness Signature (REQUIRED)

6/14/2023
Date

6.14.2023
Date