

* * * Communication Result Report (Sep. 20. 2023 6:35PM) * * *

1) AUM Warhawk Health Svcs.
2)

Date/Time: Sep. 20. 2023 6:26PM

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 Phone: 334-244-3281
 Fax: 344-244-3396



**ALBURN UNIVERSITY
 AT MONTGOMERY**

WARHAWK HEALTH SERVICES

Attn: Dr. Peter Knithapalli
 To: Primary Care Internists From: Dendra
 Fax: 334-244-0390 Pages: 25
 Phone: _____ Date: 9/20/23
 Re: Medical Records

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

Comments:

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 (HIPPA) 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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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>X3798</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>PRIMARY CARE INTERNISTS</u>	Date of Birth: <u> / / </u>
Address: <u>PETER KROTHAPALLI</u>	Phone: <u>(334) 262-0342</u> 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 ALL RECORDS

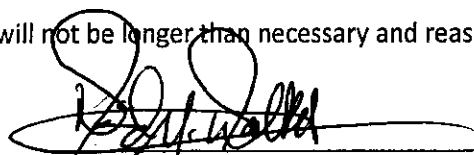
This consent may be needed at any time by the patient/client, but ending the consent will not cancel any actions that have already taken as allowed by this form. Unless the client wishes to cancel this consent at an earlier time, it will automatically stop upon the date and/or condition indicated below.

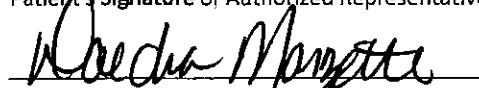
Date: _____ Event/Consent: _____

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.

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

8267
Last 4 of Patient's Social Security #


Patient's Signature or Authorized Representative


Witness Signature (REQUIRED)

9/15/2023
Date
9-15-23
Date