

TRANSMISSION VERIFICATION REPORT

TIME : 03/08/2022 12:06
NAME : ALM
FAX : 3342443396
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DATE, TIME
FAX NO./NAME
DURATION
PAGE(S)
RESULT
MODE

03/08 12:04
9131927757689741319
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02
OK
STANDARD

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



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

Attn: Medical Records

To: Unity Point Clinic

From: Daedra M

Fax: 319-277-5768

Pages: 2

Phone:

Date 3-8-22

Re: Medical Record Request

cc:

☒ Urgent

☐ For Review

☐ Please Comment

☒ Please Reply

☐ Please Recycle

with medical
records

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 & Accountability 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.



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>Channing Lawson</u>	Date of Birth: <u>04/19/1991</u>
Address: <u>4724 South Court street Apt 107</u>	Phone Number: <u>217-493-1382</u>
City: <u>Montgomery</u> State: <u>AL</u> Zip: <u>36105</u>	Email: <u>clawson clawson10@aumed</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>Unity point Clinic</u>	Date of Birth: ____/____/____
Address: _____	Phone: <u>319-277-0912</u> Fax: <u>319-277-5768</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

☒ Other: please specify Office notes and medication list showing meds patient has tried and failed for bipolar disorder

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.

Channing Lawson
Patient Name or Authorized Representative (Please Print)

3740
Last 4 of Patient's Social Security #

[Signature]
Patient's Signature or Authorized Representative

[Signature]
Witness Signature (REQUIRED)

3-8-22
Date

3-8-22
Date