

* * * Communication Result Report (Mar. 28. 2023 1:52PM) * * *

1) AUM Warhawk Health Svcs.
2)

Date/Time: Mar. 28. 2023 1:47PM

File	No. Mode	Destination	Pg(s)	Result	Page Not Sent
3672 Memory TX		912563281890	P. 10	OK	

Reason for error

E. 1) Hang up or line fail
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E. 2) Busy
E. 4) No facsimile connection
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P.O. Box 244023
Montgomery, AL 36124
Phone: 334-244-3281
Fax: 334-244-3398

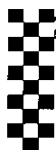
AUM | ALABAMA UNIVERSITY
AT MONTGOMERY
WARHAWK HEALTH SERVICES

Attn:

To: IBH	From: Deedra
Fax: 256-325-1890	Pages: 10
Phone:	Date: 3/21/23
Re: Medical Records	cc:
☐ 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 & 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.



Integrated
Behavioral
Health

Medical Record Request

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Medical Record Charges

All records that are released to Patients and Lawyer's Offices are subject to the following charges:

Pages 1-25 = \$1.00 per page

All pages over 25 = \$0.50 per page

Search Fee = \$5.00

Mailing Fee = Actual cost of postage

Note: Records released to physician offices will not be charged.

All fees must be paid prior to records being released.

Do you agree to the charges above?

Yes

Patient Name

Courtney Waid

Date of Birth

11/16/1974

Address

505 Azalea Park Lane, Montgomery, Alabama 36106

Phone

(701) 429-1605

By signing this form, I understand that I am authorizing the designated medical records custodian(s) for **Integrated Behavioral Health** to use and/or disclose my protected health information (PHI).

Please only select one of the below options. If you need your records released and to obtain your records from another provider, you must fill out a separate form for each request.

What is the patient needing?

Obtain Records From

Obtain Records From:

Warhawk Health Services

Address

7071 Senators Drive, Montgomery, Alabama 36117

Phone

(334) 244-3281

Fax

(334) 244-3396

Email

studenthealthservices@aum.edu

Please select the information to be released. IBH will only release records that were originated through IBH.

Billing Information

Office notes

Diagnosis

Medication List

Drug Screen Results

Date range for which you need**medical records:**

(Ex: 1/1/20-1/1/23)

From

9/1/2022

To

12/31/2022

I authorize the disclosure of the above information for the following purpose(s):

My Personal Use

Continuity of Care

Sharing with Other Healthcare Providers

I authorize records to be:

faxed electronically

emailed

mailed

-
1. I understand that this authorization, except for action already taken, may be voided by me at any time.
 2. Integrated Behavioral Health will not condition services or treatment on whether I sign this authorization.
 3. I understand that unless I have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

4. I understand that the information in my health record may include information relating to behavioral or mental health care, alcohol and drug abuse treatment or sexually transmitted diseases HIV/AIDS. Further disclosure of this information is prohibited unless expressly permitted by the written consent of the person to whom it pertains or that person's parent or guardian, as per federal regulations.
5. I understand that my records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. This includes all necessary information containing the diagnosis and records of any treatments and examinations rendered to me during the specified period, unless otherwise stated, for the purposes of continuity of care, improving assessment and treatment planning, sharing information relevant to treatment, and/or coordinating treatment services.
6. All records released to patients, disability services, and lawyers are subject to charges.
7. If this authorization is not voided, it will expire one (1) year from the date signed.

Initial



Signature of Patient/Representative

Date
3/22/2023

Relationship to Patient
Self



Witness Signature (if applicable)

Date

You may submit the requested records by: Fax: 256-325-1890, Email: medicalrecords@lbhus.com
US Mail: Integrated Behavioral Health, Attention: Medical Records
600 Sun Temple Drive
Madison, AL 35758

Revised 03/18/2021