

* * * Communication Result Report (Feb. 21. 2024 11:11AM) * * *

1) AUM Warhawk Health Svcs.
2)

Date/Time: Feb. 21. 2024 11:10AM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
6661	Memory TX	913348448256	P. 2	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: 344-244-3396



AUBURN UNIVERSITY
 AT MONTGOMERY

WARHAWK HEALTH SERVICES

Attn: Medical Records

To: State Wellness Center

From: Daedra

Fax: 844-8256

Pages: 2

Phone: 844-8670

Date: 2/21/24

Re: Medical Records Request

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

Comments: Patient has an appt this
afternoon to discuss diabetes and
hyperlipidemia

Please fax 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 (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.



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: <u>904409440</u>	
Name: <u>DAVID A BETZ</u>	Date of Birth: <u>06/24/1979</u>
Address: <u>6438 EASTWOOD GLEN DRIVE</u>	Phone Number: <u>334-868-0578</u>
City: <u>MONTGOMERY</u> State: <u>AL</u> Zip: <u>36117</u>	Email: <u>BETZDAVID187@YAHOO.COM</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>STATE WELLNESS CENTER</u>	Date of Birth: <u> </u> / <u> </u> / <u> </u>
Address: <u>101 S. UNION STREET</u>	Phone: <u>877-311-1375</u> Fax: <u> </u>
City: <u>MONTGOMERY</u> State: <u>AL</u> Zip: <u>36130</u>	Email: <u> </u>

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 Most recent office notes and lab results

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 A BETZ
Patient Name or Authorized Representative (Please Print)

David A Betz
Patient's Signature or Authorized Representative

02/21/24
Date

Last 4 of Patient's Social Security #

David A Betz
Witness Signature (REQUIRED)

2/21/24
Date