



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>Michael F. Roy</u>	Date of Birth: <u>04/23/1946</u>
Address: <u>174 Northlake St.</u>	Phone Number: <u>(251) 327-7974</u>
City: <u>Pike Road</u> State: <u>AL</u> Zip: <u>36064</u>	Email: <u>Mike.Roy36695@icloud.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>LISA Medical Center</u>	Date of Birth: <u>04/23/1946</u>
Address: <u>LISA Medical Center</u>	Phone: <u>(251) 4705890</u> Fax: _____
City: <u>Mobile</u> State: <u>AL</u> 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 Colonoscopy 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.

Michael Roy
Patient Name or Authorized Representative (Please Print)

Michael Roy
Patient's Signature or Authorized Representative

07/26/2024
Date

Last 4 of Patient's Social Security #

Daedra M. Mize
Witness Signature (REQUIRED)

7/26/24
Date