

Patient Release of Medical Records Form

Patient's Name: Deanthony Moultrie request and give my permission to release my

Medical records for the following information lab work

from the following medical facility or office _____

The Medical Records as listed above are to be released to:

Auburn University Student Health Center

P.O. Box 244023

Montgomery, AL 36124

Phone Number (334) 244-3281

Fax Number (334) 244-3396

Patient Signature Authorization

I give permission to the representatives to the Auburn University Student Health Center to obtain my medical records. I understand that verbal exchanges between the individuals or agencies may be ongoing. This consent is valid as long as I am a patient of the Auburn University Student Health Center or until I revoke my permission in writing.

Deanthony Moultrie
Signature of Patient

4/9/2019
Date

Date of birth _____

SS# _____

Full Printed Name of Patient _____

Address _____

Witness [Signature]

Date 4/15/19