MEDICAL CLINIC

400 Lem Morrison Drive
Auburn University, AL 36849
Phone: 334-844-4416 Fax: 334-528-5416
aumcmedrecords@eamc.org

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL INFORMATION

Patient information

Name:____ Date of Birth: ______/______/__________
Last First Middle
Address:____ Cell Phone : (______)__________________
City: _________________________ State:_____ Zip:______________ Email:______________________________

Please select one of the following:

☐ **Release** information **FROM Auburn University Medical Clinic** to an outside facility/clinic/person

☐ **Obtain** information from outside facility/clinic/person **TO Auburn University Medical Clinic**

Purpose of Request:

☐ New Patient Request ☐ Legal ☐ Personal ☐ Transfer out ☐ Coordination of Care

Outside Clinic/Facility Information

Name/ Facility: ____
Address:____ Phone : (______)__________________
City: _________________________ State:_____ Zip:______________ Fax: (______)__________________

Please select one of the following:

☐ Fax Records ☐ Mail Records ☐ Hold Records for Patient Pickup

Information Type(s):

☐ **Immunizations ONLY**: please specify (if all, put ALL)____________________________________

Date Range of Records Request ________/________/________ to ________/________/________

☐ **Clinic Notes**
☐ **Lab Reports**
☐ **Radiology Report/ CD** (please note there is a $16 charge for CD picked up from AU Med Clinic)
☐ **Other:** please specify____

There is a fee of $1.00 per page for the first 25 pages and $.50 per page for each additional page after 25 for any records *picked up by the patient from the AU Medical Clinic.*
There is no fee to send records from the AU Medical Clinic to another clinic/physician.
PLEASE ALLOW AUMC RECORDS DEPARTMENT 3 BUSINESS DAYS TO COMPLETE YOUR REQUEST
AUMC does not provide copies of records received from another physician or institution. Please request these records directly from the original healthcare provider.

____ ________________________
Signature (Patient's or Patient's Authorized Representative) **Date**

____ ________________________
Witness Signature **(REQUIRED)** **Date**

This authorization is valid for 90 days unless you specify otherwise. You may revoke this authorization at any time by providing a written statement to the medical record department except to the extent that AUMC has already completed the action.