

## Auburn University, AL 36849

Phone: 334-844-7651 Fax: 334-528-5418

## **AUTHORIZATION TO OBTAIN/RELEASE MEDICAL INFORMATION**

Patient information					
/ [	J				
Name:	First	Middle	Date o	f Birth:/	
Address:				one : ()	
City:					
Please select one of the fo	ollowing:				
☐ <b>Release</b> informati	on <b>FROM Miller Clinic</b>	to an outside fa	cility/clinic/person		
☐ <b>Obtain</b> informatio	n from outside facility	/clinic/person <b>T</b>	O Miller Clinic		
Purpose of Request:					
•	est 🗌 Legal 📗 P	ersonal 🔲 -	ransfer out	Coordination of Care	
			_		
Outside Clinic/Fac	illy information	J			
Name/ Facility:					
Address:				one : ()	
City:	State:	Zip:	Fa	x: ()	
Please select one of the fo	ollowing:				
☐ Fax Records	☐ Mail Red	cords	$\square$ Hold Re	cords for Patient Pickup	
Information Type(s):					
☐ Immunizations Of	NLY: please specify (if	all, put ALL)			
Date Range of Record	ls Request	<i></i>	to/		
Clinic Notes					
Lab Reports	<b>/ 05</b> / 1	. 446.1		41144 LOU: : \	
<ul><li>☐ Radiology Report,</li><li>☐ Other: please spec</li></ul>	••	_	•	-	
Utiler: please spec	۱۱۱۷			<del></del>	
		s and \$.50 per pa	ge for each additiona	l page after 25 for any record	ls <u>picked u</u> j
by the patient from the AU I		l Clinia ta anatha	. aliaia (mb. miaia m		
There is no fee to send recor PLEASE ALLOW AUMC RECO				DUEST	
AUMC does not provide cop	ies of records received f			Please request these records	directly
from the original healthcare	provider.				
Signature (Patient's or Patient's	Authorized Representative	e)		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.