PRIVIA MEDICAL GROUP

New Patient in our office

## Liberty Pediatrics & Family Medicine, LLC

Thomas Hickey, MD | Faith Frankel, MD | Jennifer Kottra, DO FAAP | Debra Lee, MD | Manuel Datiles, MD | Ashley Guy, MD
Amy Paulino, CRNP | Lori Kropfelder, CRNP | Sherry Dulling, CRNP | Jessica Kovolenko, CRNP

# AUTHORIZATION TO RELEASE information to Liberty Pediatrics & Family Medicine

Patient Name_____ DOB_____

Home Address_____

_____Phone_____

I hereby authorize_____(previous physician's name) to make uses and disclosure of my/my child's protected health information to the following entity:

**Liberty Family Medicine, LLC**
**5963 Exchange Dr, Suite 100**
**Eldersburg, MD 21784**
**410-549-0900 phone**
**410-549-6121 fax**

Previous physician's fax: #

- *We cannot fax the request without the fax number. Please make sure you include it.*

**Description of information to be disclosed:**

_____ Complete records to include yours and any medical records that had been sent to you from previous providers including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released).
_____ Abbreviated Record- including immunization record, growth charts, summary of visits and most recent physical exam
_____ Records regarding treatment for the following condition or injury_____ on about_____
_____ Records covering the period of time from _____to_____
_____ Other (please specify – include dates) _____

**Reason for requested use or disclosure: _____**

**To be read and signed:**

1. I may revoke this authorization at any time by providing written notice to the practice.
2. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization.
3. The practice will not condition treatment or payment based on my signing this authorization.
4. I am signing this authorization freely and no one has pressured me to sign it.
5. The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
6. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
7. I have received a copy of this authorization.
8. Would you like records returned to you (please circle)? YES NO

Signature_____

Event or Date Authorization will expire:_____

registered by _____ faxed by _____