PRIVIA HEALTH

New Patient in our office

Liberty Pediatrics & Family Medicine, LLC

Thomas Hickey, MD | Manuel Datiles, MD | Amy Paulino, CRNP | Lori Kropfelder, CRNP | Joanne Desmond, CRNP | Anna Turpin, CPNP | Elizabeth Hall, CPNP | Erin Picotte, CRNP | Sherry Dulling, CRNP | Jessica Kovolenko, CRNP | LaVon Magruder, CRNP | Zoe Ajebon, DO | Samantha Hall, NP

AUTHORIZATION TO RELEASE information to Liberty Pediatrics & Family Medicine

Patient Name _____DOB _____

Home Address _____Phone_____

Patient, Parent, or Guardian email address (please circle which one) _____

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 Pediatrics & Family Medicine, LLC
5963 Exchange Dr., Suite 100
Eldersburg, MD 21784
410-549-0900 phone
410-549-6121 fax

Previous Physicians fax #:

_____

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

Description of information to be disclosed (please check):

_____ 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 Records – 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: _____

Please read and sign below. WE CAN NOT REQUEST RECORDS WITHOUT A SIGNATURE AND DATE!

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.

Signature _____ Date: _____ Relation to patient _____

This form will expire in one year or on the date provided: _____