Elizabeth A. Liotta, MD, LLC

77 Thomas Johnson Drive, Suite C
Frederick, MD 21702
301-668-3004

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

Date: _____

I do hereby authorize Elizabeth A. Liotta, MD, to disclose my health information, including medical records, and discussion of treatment and laboratory results to the following person(s):

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand there may be a charge for copying, handling, and forwarding medical records, and all fees will be in compliance with applicable state guidelines. I agree to pay these fees as applicable to this request.

Print Patient Name | Date of Birth | ID Number

Address

City | State | Zip

Signature | Phone Number

For (check one): _____ Healthcare Agent _____Guardian _____Surrogate _____Parent

I (print name), _____, am the representative for the patient as indicated above.

_____ _____ _____

Signature | Address | Phone