Laura Lieberman, M.D., P.A.
332 140 Village Road
JCK Center - Suite 1
Westminster, MD 21157
410-876-9680

Keun Hee Oh, M.D. Melissa Levine, M.D. Nicholas DeAngelis, M.D.

CONSENT FOR TREATMENT AND TO USE AND DISCLOSE INFORMATION PATIENTS 18 YEARS AND OLDER

The office is required by federal regulations to inform our patients in regards to use of your health information in accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

I understand that as part of my healthcare, Laura Lieberman, M.D., P.A. originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments and any plans for future care or treatment.

I understand that as of my 18th birthday, I am considered an adult. Therefore, I need to give written consent for treatment and to discuss my medical treatment with anyone other than myself including my parents. By signing this form, I am designating the parties below with whom I wish Laura Lieberman, M.D., P.A. to be able to discuss my medical information. I understand that it is my responsibility to inform Laura Lieberman, M.D., P.A. in writing of any changes pertaining to this release.

I, _____ hereby authorize Laura Lieberman, M.D., P.A. to discuss with and release medical information to the individuals below. This release is written without restriction and includes information related to mental and behavioral health.

Name: _____ Relationship to Patient _____

Name: _____ Relationship to Patient _____

Name: _____ Relationship to Patient _____

I understand that as part of the organization's treatment, payment or healthcare operations it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for permitted uses.

_____ _____

Signature Date

Patient contact # _____ (best number to reach you, i.e. cell phone)

Patient email: _____ (to set up new portal account)