LAURA LIEBERMAN, M.D., P.A.
Pediatrics
332 140 Village Road, JCK Center – Suite 1
Westminster, Maryland 21157

Keun Hee Oh, M.D. 410-876-9680 – *phone*
Melissa Levine, M.D.
Nicholas DeAngelis, M.D. 410-386-0876 - *fax*

AUTHORIZATION FOR THE DISCLOSURE OF MEDICAL INFORMATION

From*: _____

_____

_____
*enter name and address or fax number of provider from who records are being requested to be sent to our office.

The undersigned hereby authorizes you to provide to Dr. Laura Lieberman, Dr. Melissa Levine, and/or Dr. Keun Hee, Oh. the following information:

_____ Vaccines, last well child visit & lead results faxed to: 410-386-0876

_____ Complete Medical Record mailed to Laura Lieberman, M.D., PA
332 140 Village Road, Suite 1
Westminster, MD 21157

_____ Specific information:_____

For the following patient(s):

Patient's Name	Birth Date	Parent's Name

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and no longer protected by HIPAA Privacy Rule.

Reason for request:
_____Moving out of area _____ Insurance Change _____ Other

Parent's Signature _____ Date_____**
**Authorization expires one year from date of signature unless otherwise noted.

Address: _____

Telephone Number_____