RALUCA RADULESCU, M.D., LLC

140 Route 17 North , Paramus, NJ, 07652

Phone:201 445 1990

Fax:201 445 1992

Consent to Treatment

Patient_____

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above provided by_____. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the treatment may be discontinued at any time by either party, after an appropriate plan for discharge has been made.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content.

Patient's Notice of Confidentiality: The confidentiality of patient records maintained by Raluca Radulescu, MD&Associates is protected by Federal and/or State law and regulations and not released to third party unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research or audit.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Physician's duty to warn any potential victim, when a significant threat of harm has been made. Parents or legal guardians of non-emancipated minor patients have the right to access the patient's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about patient, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original.

I consent to treatment and agree to abide by the above stated policies and agreements with_____

_____ _____

Signature of Patient/Legal Guardian Date

(In a case where a patient is under 18 years of age, a legally responsible adult acting on his/her behalf)