HARFORD MEDICAL WEIGHT LOSS, LLC

1621 Belair Rd., Suite B
Fallston, MD 21047
Phone: 410-877-8772
Fax: 410-877-8773

Acknowledgement and Consent

By signing below, I acknowledge that I have been offered a copy of Harford Medical Weight Loss, LLC's, "Notice of Privacy Practices". I have therefore been advised of how health information about me may be used and disclosed by Dr. Barbara Watunya, LLC. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of Dr. Barbara Watunya, LLC.

With my consent, Harford Medical Weight Loss, LLC, may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and health care options (TPO).

With my consent, Harford Medical Weight Loss, LLC, may initiate a complaint to the Insurance Commissioner for any reason on my behalf.

With my consent, Harford Medical Weight Loss, LLC, may deposit checks received on my behalf when made out to the Policy holder and received by this office.

With my consent, Harford Medical Weight Loss, LLC, may call my home or other designated location and leave messages on voicemail or discuss in person in reference to any items that assist the practice in carrying out TPO, such as appointment remainders, insurance items and any call pertaining to my clinical care, including laboratory results.

With my consent, Harford Medical Weight Loss, LLC, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment remainder cards and patient statements.

Patient Authorization for Release of Protected Information

Before Harford Medical Weight Loss, LLC, can permit a family member or other designated person to have access of your PHI, we must first obtain your authorization. You understand if someone requests access to your PHI and we do not have your authorization we may refuse to provide access to this information.

The following have my permission to receive PHI for treatment, payment or telephone contact and/or to be in the exam room with you or speak with the physician or staff concerning your care.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Name: _____ **Date of Birth:** _____

Signature of Patient: _____ **Date:** _____