HARFORD MEDICAL WEIGHT LOSS, LLC

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

EXCHANGE / RELEASE of MEDICAL HISTORY CONSENT

I, _____, by signing this form, give my informed consent and permission to HARFORD MEDICAL WEIGHT LOSS, LLC to speak with and/or exchange any/all of my medical history with any/all of my health care providers (primary care physicians, specialists, nurse practitioners, physician assistants, medical office staff, pharmacists, etc.) below, I consent to, and assume all responsibility for the release of this information.

_____

Signature of Patient Date

_____

Patient's Printed Name

PLEASE NOTE: If you have received this fax in error, please contact our office immediately.

This information is strictly confidential and is only is to be viewed by the intended recipient.

Thank you.