Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I can receive a copy of Dr. Borgardt's / TNC, Inc. Weight Loss Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available from the receptionist and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Authorization to Release Medical Information / Records

I hereby request that Philip Borgardt M.D., Inc. / TNC, Inc. Weight Loss has authorization to request any records and/or information necessary to complete treatment on my behalf. I also authorize Dr. Borgardt to provide in writing to my doctor, hospital, a report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to this treatment of me. This authorization will remain valid until revoked in writing by myself.

Authorization for Records Request

I hereby authorize the release of my medical records to:

Philip Borgardt M.D., Inc. / TNC, Inc. Weight Loss
865 Aerovista Place, Suite 210
San Luis Obispo, CA 93401
Ph: 805-540-5544
Fax: 805-528-1690

Signature: Date:

Print name: