Balance and Neuro Physical Therapy
4141 SW Frwy Ste #100
Houston, Tx 77027
Ph# (713) 223-1800
Fax# (713) 223-1801
Houston's Total Balance Solution

Date:_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I, _____acknowledge that I have received a copy of the Notice of Privacy Practices from Center For Balance and Neuro.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative & Relationship Date
(Required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____