ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES The Center for Balance

My signature below indicates that I have been given the Notice of Privacy Practices for The Center for Balance. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to The Center for Balance to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name & Date

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Patient's or Authorized Representative's Signature