BODY IN BALANCE PHYSICAL THERAPY

ACKNOWLEDGMENT of RECEIPT of the
NOTICE of PRIVACY PRACTICES of

BODY IN BALANCE PHYSICAL THERAPY, INC.
herein after referred to as the Clinic,

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices, I understand that these privacy practices will be followed by the Clinic and ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print): Date:

_____ _____

Signature of Patient, Legal Guardian or Patient's Legal Representative:

_____

Please list below the name and your relationship of the people to whom you authorize the Clinic to release your private health information.

Print Name: Relationship:

_____ _____

_____ _____

_____ _____

This form will be placed in the patient's chart and maintained for six years.