**HELEN M. SCHILLING, M.D.**

Physical Medicine and Rehabilitation

17320 Red Oak Drive ▪ Suite 104 ▪ Houston, Texas 77090

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T: 281. 586. 0542

F: 281. 586. 0543

**Acknowledgement of Receipt of Privacy Practices**

I have been presented with a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under Federal and State law and outlining my rights regarding my health information.

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Signature Date

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Please list family or friends with whom we may disclose your health information:

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Name Relationship

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Name Relationship

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Name Relationship