HOUSTON NEUROCARE, P.A.
NERVE AND MUSCLE CENTER OF TEXAS
AZIZ SHAIBANI, M.D.

PRIVACY PRACTICES ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have been given an opportunity to request or review a copy of our *Notice of Privacy Practices* which describes how medical information about you may be used and disclosed and how you can get access to that information.

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Patient Name: _____
(Please Sign Name)

Patient Date of Birth: _____

May 2017