CENTER FOR MEN

PRIVACY PRACTICES
PATIENT RECEPTION FORM

I have received or reviewed the Privacy Practice Notice for Center for Men, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application for Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient Name _____

Patient Signature _____

Date _____