

HIPPA Privacy Practices Patient Reception Form

I have received or reviewed the Notice of Our Privacy Practices (2 pages) for Sheffrin Men's Health, 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 Patient Registration Form) 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 Signature _____ Date _____

Patient Name (Print) _____