PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

I have received and/or reviewed the privacy practice notic for Atlanta Men's Clinic, 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 whenever that may have occurred.

I understand that this company 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

_____

Print the Patient Name