UROLOGY CENTER OF FLORIDA

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient: ______________________________

By my signature on this form, I acknowledge that I have received a copy of the Practices Notice of Privacy Practices. The Notice describes how my health information may be used.

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Patient Signature/Date

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Representative’s Signature if Patient Unable to Sign/Date

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TO BE COMPLETED ONLY IF ABOVE FORM IS NOT SIGNED BY PATIENT/REPRESENTATIVE

□ Patient/representative was presented with a copy of the Practice’s Notice of Privacy Practices. Notice was explained/discussed, but acknowledgement form was not signed.

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Staff Signature/Title/Date