MID-ATLANTIC
BRAIN & NEUROLOGICAL
REHABILITATION

Privacy Practices ~ Reception Form

I have received or reviewed the Privacy Practice Notice for Mid-Atlantic Brain and Neurological Rehabilitation, 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 Signature Date

_____

Patient Name Printed