

PRIVACY NOTICE ACKNOWLEDGEMENT

I do understand this office may disclose health information about me to a family member, other relative or close personal friend other than the person(s) listed under my emergency contact, when the health information is related to that person's involvement with my care or payment for my care and at this time I do have the opportunity to stop or limit the disclosure.

I have been fully informed and thoroughly understand all of the above statements and I acknowledge that I have received a copy of Lamar Robinson, M.D. Privacy Notice.

Signature of Patient

DATE

Signature of Witness

DATE