

Acknowledgement of Receipt of Notice of Privacy Practices

JEROME LAMB, MD PC reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for
JEROME LAMB, MD PC.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient