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Acknowledgement of Receipt

Notice of Privacy Practices

Patient Name: _____ DOB: _____

Your name and signature on this page indicates that you have been given the opportunity to review and request a copy of the Leo W. Mack, Jr., M.D., P.A. *Notice of Privacy Practices* on the date indicated. If you have any questions regarding the information in our *Notice of Privacy Practices*, please do not hesitate to contact the administrator as indicated on your Notice.

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