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ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or Legally Authorized Representative (“Agent”) of the Patient acknowledges he or she personally received a copy of the Dr. Michael Ducato, M.D., P.C. Notice of Privacy Policies as indicated below:

Signature: ______________________________ Date: ______________

Patient: ______________________________
(Print Name)

Information about Agent (Attach appropriate documentation):

Agent: ______________________________

Title: ______________________________