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2770 W Dublin Granville Rd
Columbus, OH 43235

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I ____, Patient's Date of Birth: ____________
(Please Print Your Name)

have received a copy of this office's Notice of Privacy Practices and have been provided an opportunity to review it.

____ ______________
Signature of Patient or Parent, Guardian or Personal Representative Today's Date