



MARC L. CHAIKEN M.D. AND ASSOCIATES

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**Receipt of Notice of Privacy Practices
Written Acknowledgement Form**

I _____, have received a copy of
Marc L. Chaiken, M.D. and Associates/ Columbia Surgery Center
Notice of Privacy Practices.

I also give permission for the following:

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OR ON THE ANSWERING MACHINE:
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**CALL / LEAVE MESSAGES ON VOICE MAIL
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**LEAVE MESSAGES VIA EMAIL
_____** _____ YES _____ NO

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DATE