

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT

Patient Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the **Ned Zallik, M.D., PLLC ("Practice")** "Notice of Privacy Practices" ("**Notice**"). This Notice is located online at www.nedzallikmd.com, and a physical copy is also available at any physical office location(s) where Practice provides services.

I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Ned Zallik, M.D. at 224-496-6772.

Signature of Patient

Date