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ACKNOWLEDGEMENT OF REVIEW AND GENERAL CONSENT

I acknowledge that I have reviewed Family Vision Care Associates, LLP's Notice of Privacy Practices. I am aware that I may receive a copy of the Notice of Privacy Practices upon request.

I further consent to the release of my health information for purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Print Patient Name____

Signature____Date_____________________________

If anyone other than patient signing this form:

Print Name____

Relationship to Patient____