



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

THE ATTACHED NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I have received the attached Multack Eye Care Notice of Privacy Practices.

_____ Signature of Patient	_____ Date of Signature
_____ Patient's Printed Name	_____ Date of Birth or Medical Record Number
_____ Signature of Parent/Legal Guardian/Legal Representative	_____ Date of Signature
_____ Parent/Legal Guardian/Legal Representative Printed Name	_____ Relationship to Patient

This Notice is effective September 1, 2021.

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