

Acknowledgement of Receipt of Notice of Privacy Practices

Family Eye Care
2616 Pointe North Blvd.
Albany, Ga. 31721
229-435-7795

I acknowledge that I have received the *Notice of Privacy Practices* from Family Eye Care.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient

Print Name