

**FLORAL PARK OPHTHALMOLOGY**

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**HIPAA ACKNOWLEDGEMENT**

I, \_\_\_\_\_, acknowledge  
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I give permission for my medical condition, treatments and or records to be discussed with and or released to the following people:

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3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or Representative)