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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Patient Name**_____

The attached Notice of Privacy Practice describes how Dr. Dennis P. Morehart, D.D.S. and his professional staff may use and disclose your medical and dental information and how you can get access to this information. Please review it carefully. If you have any questions about the Notice, please contact our Privacy Officer at (580) 237-2213.

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE:** A complete copy of Dr. Morehart's Notice of Privacy Practice is attached hereto and by signing below you acknowledge that you have received a copy of Dr. Morehart's Notice of Privacy Practice. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

_____Date_____
Signature of Patient

**IF PATIENT IS A MINOR OR INCOMPETENT:** I hereby acknowledge that I have received a copy of Dr. Morehart's Notice of Privacy Practice on behalf of the patient. I also consent to Dr. Morehart's use and disclosure of patient's protected health information to carry out treatment, payment activities, and healthcare operations.

_____Date_____
Signature of Person Authorized to Consent for Patient

_____
Relationship to Patient