

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT TO TREAT

I have had the opportunity to read and consider the contents of the privacy policy. I acknowledge that a copy of MSD's Privacy Policy is available for me or my personal representative. I understand, by signing this form, I am confirming my written permission for the disclosure of my protected health information as described in the Privacy Policy, as warranted.

	Please Print PATIENT NA	ME	
	Signature		Relationship
	Date		
If this conse patient, cor	ent is signed by a penplete the following	ersonal representative / par g:	ent on behalf of the
Personal Re	epresentative's / Par	rent's Name:	
Relationship	p to Patient:		
l authorize t	the release of my in	formation to the specified	person(s) involved in my
		Relationship to Patient:	
		Relationship to Patient:	
			Acknowledgment & Conse Revised: 08-11-20

1020 Menomonie Street ~ Eau Claire, WI 54703 ~ 715-834-8161 ~ www.MSDsmile.com Dr. S.H. Van Gorden Dr. James Friedeck Dr. Eric Carlson Dr. Derek Rognlien Dr. Karilynn Peper Dr. Brittany Huiras "Smiles created to make a lasting impression."