Michael G. Sargent D.D.S.
David Markham D.M.D
Franklyn Liberatore, D.M.D

ACKNOWLEDGEMENT OF NOTICE PRIVACY PRACTICES

I _____ acknowledge that I have read and understand the Office of Dr. Sargent and Dr. Markham's privacy practices. This notice describes certain restrictions on the use and disclosure of my protected healthcare information, rights that I may have regarding my protected healthcare information, and how this dental office and the staff may use and disclose my protected healthcare information.

By signing this agreement, I also give Dr. Sargent and Dr. Markham's office and the staff permission to contact me by telephone or mail and to leave messages on an answering machine if necessary, to confirm and schedule any future appointments or conferences.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient