Notice of Receipt and Consent of Privacy Practices for the Office of Donald A. Tucker, DDS

I acknowledge that I have received and reviewed the Notice of Privacy Practices of Dr. Donald A. Tucker's dental office.

I understand that I may revoke this consent in writing at any time, except to the extent that the office has taken action relying on this consent.

_____ _____

Patient's Name **Date**

_____ _____

Signature of Patient ***(or legal representative)*** **Date**

_____

Legal Representative's Relationship to Patient