DR. KYLE M. TRIGGS, D.M.D., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES" AND CONSENT

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES."

As required by the Privacy Regulations, _____
(NAME OF STAFF MEMBER)
from this practice, has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that this practice included a provision that it reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information it maintains.

The undersigned herby authorizes Dr. Kyle M. Triggs to perform any number and all forms of dental treatment that may be indicated and further authorizes Dr. Kyle M. Triggs to choose and employ such assistance as deemed appropriate.

_____ _____

Print Name **Date**

_____

Signature