Lake Cumberland
ENDODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA), 1996

OFFICE OF SHEA CHEAVRONT, DMD
87 SARAH'S LANE
SOMERSET, KY 42503

Purpose of consent: 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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including and revisions of our Notice, at any time by contacting:

LAKE CUMBERLAND ENDODONTICS, 87 SARAH'S LANE, SOMERSET, KY 42503, 606-679-3010

Right to Revoke: You will have right to revoke !his Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any we took in reliance on this Consent before we received your Revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and dislosure of my protected information to carry out treatment, payment activities, and healthcare operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFFER YOU HAVE SIGNED IT. PLEASE ADVISE US IF YOU WOULD LIKE A COPY.