LIGHTSHIP DENTAL, INC.

HIPAA Patient Consent and Acknowledgment Form

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe.

Lightship Dental, Inc. ("Lightship Dental") requests that each patient signs this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment., payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the privacy officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Lightship Dental may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Printed Name of Legal Guardian (if applicable)

_____ ____/____/____ _____

Patient's Name Patient's DOB Date Signed