



**KENNETH L. ODINET, D.D.S., M.D., APMC**  
PLASTIC AND RECONSTRUCTIVE SURGERY

---

200 Beaulieu Drive, Bldg. 6, Lafayette, LA 70508 Phone: 337-234-8648 Fax: 337-233-0244

**CONSENT TO USE OR DISCLOSE HEALTH INFORMATION**

My "Protected Health Information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I hereby acknowledge that I have received the **Kenneth L. Odinet, D.D.S., M.D., APMC Notice of Privacy Practices, Patient Financial Policy, and Patient Rights and Responsibilities.**

---

Print Name of Patient

---

Patient's Date of Birth

---

Signature of Patient or Person Authorized by Law

---

Date

**ASSIGNMENT OF BENEFITS**

I, \_\_\_\_\_ hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Private Insurance and any other health plan to Kenneth L. Odinet, D.D.S., M.D., APMC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is as valid as the original. I understand that I am financially responsible for all charges, whether paid in full or in part by any source. I fully understand that all delinquent accounts are subject to any expenses, collection fees and/or attorney fees.

---

Signature of Patient or Legal Guardian

---

Date