THE CENTER FOR COSMETIC SURGERY & medi Spa

DEAN P KANE, MD, FACS, PA
LAURI P KANE, RD, MPH, SCD

EXECUTIVE CENTRE AT HOOKS LANE
1 RESERVOIR CIRCLE, SUITE 201 • BALTIMORE, MD 21208
DeanKane@DrDeanKane.com • www.DrDeanKane.com
410.602.3322

# NOTICE OF PRIVACY PRACTICES:

## ACKNOWLEDGEMENT OF NOTIFICATION

By signing this form, you acknowledge having been offered the *Notice of Privacy Practices of Dean P Kane, MD, FACS, PA.* Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. While a summary is found on the reverse side of this form, we encourage you to read the Notice of Privacy Practices in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our practice in writing.

If you have any questions about our *Notice of Privacy Practices,* please contact our practice in writing.

I acknowledge having been offered the *Notice of Privacy Practices* of *Dean P Kane, MD, FACS, PA.*

Signature: _____ Date: _____
*(patient/parent/conservator/guardian)*

## INABILITY TO OBTAIN ACKNOWLEDGEMENT OF NOTIFICATION

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

☐ Patient refusal
☐ Other:

Signature of Dr. Kanes representative: _____ Date: _____