F.Thomas Dean, M.D
Shannon Barnett, WHNP
Brandy M. Valentino, WHNP, CNM

NOTICE OF PRIVACY PRACTICES ACKOWLEDGEMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party pay payers.
- Conduct normal healthcare operations such as quality assessments and physicians' certification.
- I was given an opportunity to read, and understand the Notice of Privacy Practices for F. Thomas Dean M.D. description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to obtain and that I may contact this organization at any time at any I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions. This notification does not have an expiration date and will remain in force unless I decide to update or change it.

PATIENTS NAME: (please print): _____ Date of Birth: _____

_____REALTIONSHIP TO PATIENT (if other than patients):

_____ SIGNATURE: _____DATE:

I HEREBY AUTHORIZE F. Thomas Dean, M.D. to release medical information to the person listed below. Please write in "none" if you do not authorize any other persons to have access to your information.

FULL NAME RELATIONSHIP TO PATIENT PHONE NUMBER

_____

_____