Mark A. Greenfield, D.O., P.C.
4344 W. Bell Rd.
Glendale, AZ 85308

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

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

- Conduct, plan and direct my treatment and follow-ups among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from insurance companies and third party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time, and I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment , payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature (Patient or Guardian): _____

Relationship to Patient: _____

Date: _____

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OFFICIAL USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement and Consent, but was unable to do so as documented below:

Date:	Initial:	Reason: