Marie Britz, M.D.

HIPAA CONSENT FORM
(Consent for Purposes of Treatment, Payment and Healthcare Operations)

I consent to the use or disclosure of my protected health information by Marie Britz, MD for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dr. Marie Britz' practice. I understand that diagnosis or treatment of me by Dr. Marie Britz may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Marie Britz is not required to agree to the restrictions that I may request, however, if Dr. Marie Britz agrees to a restriction that I request, the restriction is binding on Dr. Marie Britz and her staff. (We would like to assure our patients that we adhere to most reasonable requests).

Restrictions: _____

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I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Marie Britz has taken action in reliance on this account.

My "PHI - Protected Health Information" 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, billing service or a health care clearinghouse. This PHI relates to my past, present and/or future physical and mental condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Dr. Marie Britz' Notice of Privacy Practices by mail or by obtaining one at her office. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Marie Britz. This Notice of Privacy Practices also describes my rights and responsibilities with respect to my PHI. I may obtain a revised Notice of Privacy Practices by calling the office and request a revised copy to be sent in the mail or obtain one at the time of my next appointment.

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Signature of Patient or Legal Guardian Date