Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) provides patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health. Mental health care providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. Therefore, you may have already received a similar notice from your other health care providers.

This Patient Notification of Privacy Rights is in its simplest form, and the purpose intended is to inform you of your rights as a patient. Please read this document as it is important you know what protections HIPAA affords all patients. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship. As your therapist, I will follow the regulations set forth to protect the privacy of your mental health records. If you have any questions about this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights. Thank you for your consideration in reading and acknowledging your receipt of this information by providing your signature below.

Connie Taylor

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Licensed Marital and Family Therapist (LMFT)

I, _____, understand and have been provided a copy of the Patient Notification of Privacy Rights which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____
Patient Signature Print Patient Name Above

_____ _____
If Minor, Signature of Parent/Guardian If Minor, Print Parent/Guardian Name Above

_____
Relationship to Patient

_____
Date