Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protection 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 the storage and access to health care records ("security rules"), HIPAA applies to health care providers, including mental health care, and 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. You may have already received similar notices such as this one from your health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document; as it is important you know what patient protections HIPAA affords to all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find I make every effort to do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, New Beginning Counseling, LLC is required to secure your signature indication you have received a copy of the Patient Notification or Privacy Rights document.

New Beginning Counseling, LLC/Mark M. Ellison, LMFT

HIPAA Compliant Officer

Patient Name (print) _____

I have received a copy of the Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information and my rights on these matters. I understand that I have the right to review this document and that I may at any time, nor or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian Signature Date