File No. ___________

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PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protection 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 healthcare 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 other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp without formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple, comprehensive fashion. Please read this document to assist you in understanding the patient protections HIPAA affords. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find that I do all I can to protect the privacy of your mental health records. If you have any questions about any matters discussed in this document, please ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

I, ____________________________, understand and have been provided a copy of Dr. Hauenstein's Patient Notification of Privacy Rights document 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.

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Patient Signature or Parent if minor or Legal Charge **Date**

If legal charge, describe representative authority: ______________________________