The Family Center
Barkley & Associates, Inc.

"Strengthening relationships through harmony."

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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 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 care providers. 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 you other health care providers.

As you might expect the HIPAA law and regulations are extremely detailed and difficult to grasp if you do not have formal legal training. Our Patient Notification of Privacy Rights is our 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 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 we do all we can do to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in the document, please do not hesitate to ask for further clarification.

By law, we are required to secure your signature indicating you have received the Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

Barkley & Associates, Incorporated

I, _____, understand and have been provided a copy of Barkley and Associates 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 acknowledgement form.

_____ _____

Patient Signature or Parent Signature (if client is a Minor or Legal Charge) Date