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PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance and Accountability Act (HIPAA) has created new patient protection s 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. All health care providers and 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.

The HIPAA law and regulations are extremely detailed and somewhat lengthy. 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 that 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 I will do all I can to protect the privacy of your mental health records. If you have any questions about ay of the matters discussed in 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 Document. Thank you for you thoughtful consideration of these matters.

Susan E. Hammonds-White, Ed.D.
Licensed Professional Counselor/MHSP

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

Patient Signature of Parent if Minor or Legal Charge

Date

If Legal Charge, Name of Identified client _____