



Karen Pierpoint, MS, LMFT

Marriage and
Family Therapist

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Client 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 and health care agencies throughout the nation 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 if you don’t have formal legal training. My Client 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 for you to know what patient protections HIPAA affords you. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship. You will find that this office will do all it 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, I am required to secure your signature indicating that you have received this Client Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

Acknowledgement of Receipt of Privacy Practices Document

I, _____, understand and have been provided a copy of Karen Pierpoint’s Client 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 in these matters according to the HIPAA. I understand that I have the right to review this document before signing this acknowledgement form.

Print name of client

Date of birth

Signature of Client, or Parent if minor is being treated

Date

Relationship to Client of person signing notification