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 transmission rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients with notification of the 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 do not have formal legal training. The **GEORGIA NOTICE FORM: What You Should Know About Confidentiality** 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 make every effort to do all we 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 Hope Counseling Center is required to secure your signature indicating you have been given the opportunity to receive a copy of the **GEORGIA NOTICE FORM: What You Should Know About Confidentiality and the handling of your confidential health information.**

I have reviewed a copy of GEORGIA NOTICE FORM: What You Should Know About Confidentiality, 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 that I have the right to review this document and that I may, at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates that I have received a copy.

____________________________________ ________________________________
Printed name of client(s) Printed name of parent/guardian

____________________________________ ________________________________
Signature of client, or parent/guardian Date

(The signature of the custodial parent or guardian is required for clients under 18 years of age.)