



**Patient Notification of Privacy Rights
Health Insurance Portability and Accountability Act (HIPAA)**

Recent federal law, 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 (“transaction 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, and providers. All healthcare agencies throughout the country are 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 from your other healthcare professionals.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you do not have formal legal training. This Patient Notification of Privacy Rights is designed to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you what patient protections HIPAA affords all of us. In mental healthcare, confidentiality and privacy are central to the success of the therapeutic relationship and such. You will find we will do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discusses in this document please do not hesitate to ask for further clarification.

HIPAA requires that we secure your signature indicating you have received or been offered the Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

Kind regards,
New Jersey Community Spine and Pain

The staff of Community Spine and Pain has offered me a copy of the Patient Notification of Privacy Rights that gives a detailed description of the potential uses and disclosure of my protected health information, as well as my rights on these matters. Please check one of the following:

I have accepted a copy of the Patient Notification of Privacy Rights document. _____

I have been offered a copy of the document and DO NOT want a copy at this time. _____

I understand I have the right to review the document before signing this acknowledgment form.

Patient Name/DOB

Signature/Date