# ACCARES Wellness Center
# 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 ("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 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. This 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 make every effort to do all we can to protect the privacy of your mental health records. If you have any further question about any of the matters discussed in this document, please do not hesitate to ask for further clarification.**

**By law, ACCARES Wellness Center is required to secure your signature indication you have received a copy of the Patient Notification of Privacy Rights document.**
**ACCARES Wellness Center HIPAA Compliance Officer**

**Patient name (print)** _____

**I have received a copy of the ACCARES Wellness Center 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 that I have the right to review this document and that at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.**

**Patient Signature** _____

**Parent Signature if Patient is a minor** _____

**Guardian Signature if Patient is Legal Charge** _____