**Patient Notification of Privacy Rights**

**Soldiers and Families Embraced (SAFE)**

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of 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, 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 can be extremely detailed and difficult to grasp without formal training. This form is an attempt to inform you of these rights in a simple yet comprehensive fashion. Please read this document, as well as the full patient privacy form included in these intake papers, so that you are aware of what patient protections HIPAA affords. If you have any questions about this document or the attached patient privacy form, please ask for further clarification.

By law, Soldiers and Families Embraced is required to secure your signature indicating that you have received this Patient Notification of Privacy Rights Document.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand and have been provided a copy of SAFE’s 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 before signing this acknowledgement form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (or Parent if Minor or Legal Charge) Date