Date: _____

STATEMENT REGARDING PRIVATE HEALTH INFORMATION:

Name: _____

It is the intent of this office to be in compliance with the Privacy Standards for Private Health Information (PHI) covered under Health Insurance Portability and Accountability Act (HIPAA).

- I understand that I have the right to request that certain information be excluded from my record unless the information is related to my diagnosis or is related to one of the exceptions listed on page 3 of the Therapist – Client Responsibilities.

- I understand that I have the right to amend information but not expunge ("erase") information from my record.

- I understand that I have the right to inspect and/or receive a copy of my Private Health Information (PHI) i.e. Record unless it is legally determined that it would adversely affect my well-being or I am a minor. My request must be fulfilled by this office within 60 days of my written request. There will be a charge for copies.

- As additional HIPAA regulations are mandated and clarified, this office will be altering its policies and procedures to be in compliance.

- If this office is found to be in violation of the Primary Standards put forth in HIPPA, I am urged to speak with my therapist and if not resolved, I have a right to file a formal compliant with the Office of Civil Liberties.

I have read and received a copy of the above Privacy Standards for Private Health Information covered under HIPPA.

Signed: _____ Date: _____