HIPPA FORM (Notice of Privacy Practice)

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HIPPA is the Health Insurance Portability and Accountability Act of 1996 which clarifies your right as a patient both access to your protected health information and your ability to control its use and disclosure.

Because of your right to privacy protected health information includes anything than can identify you inclusive of name, address, or telephone #. Psychotherapy notes are even further restricted. No information about your health information can be released to anyone without your written permission and then only the minimal amount is released for its intended purpose.

You have the following rights with regard to your Private health information (PHI):
*The right to restrict its uses and disclosures including family members and friends
*The right to inspect and copy and amend your PHI.
*The right to receive an accounting of disclosures
*You have the right to revoke or cancel this authorization by putting your request in writing.
*You have the right to refuse to sign this authorization.
*You must receive a copy of this form and signed authorization.

Psychotherapy notes are kept separate so that when information is released with your permission, only the minimum necessary is released..such as the date and length of the contact, the modality individual or couple, and any medications prescribed, while details of conversations are not.

Acknowledge Receipt of Notice of HIPPA and Privacy Practice

I am a patient of: Brian L. Ackerman MD and hereby acknowledge receipt of privacy practice and my rights of access and disclosure of my personal health information.

Name _____ (Print)
Signature _____
Date _____
I am a parent or legal guardian of _____
and hereby acknowledge receipt of the access and disclosure
of the personal health information of: _____
Relationship to patient _____ Parent _____ Legal Guardian
Date _____