

Optimal Health Consulting
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CLIENT/PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPPA) has created new client/patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPPA provides client/patient protections related to the electronic transmission of data (“the transaction rules”), the keeping and use of client/patient records (“privacy rules”), and storage and access to health care records (“the security rules”). HIPPA applies to all health care providers, including wellness care; and providers and health care agencies throughout the country are now required to provide clients/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 HIPPA law and regulations are extremely detailed and often difficult to grasp if you don’t have formal legal training. Our client/patient notice of privacy rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document since it is important you know what client/patient protections HIPPA affords all of us. In wellness care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, we will do all we reasonably can do to protect the privacy of your wellness records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask us for further clarification.

By law, we are required to secure your signature indicating you have reviewed this client/patient notification of privacy rights document, and have been offered a copy of the document, if you so desire. Thank you for your thoughtful consideration of these matters.

I, _____, understand and have reviewed a copy of Integrative Wellness and Research Center’s Notice of Privacy Practices (NPP), 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 I have the right to review this document before signing this acknowledgement form, and that a copy of this document is also available upon request.

Client/Patient Signature(s)

Date