PREMIER PSYCHOLOGICAL
COUNSELING & CONSULTING, PC
PREMIER TMS
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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 (PHI). Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data (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 psychologists.

Health care providers, health care agencies, and health insurance companies throughout the country are now required to provide patients a notification of their privacy rights as related 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, HIPAA regulations are extremely complex and detailed. **Premier PCC/Premier TMS Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information** describes how mental health information about you may be used and disclosed, and how you may get access to this information. **Our privacy policy is provided with this Notification Document. If you would like a personal copy of this document, please ask us for one.**

Please read this document, as it is important for you to know what patient protections HIPAA affords you. 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, Premier PCC/Premier TMS is required to secure your signature indicating you have received this Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information.

Thank you for your thoughtful consideration of these matters.

I, _____, have been provided access to Premier PCC/Premier TMS's Policies and Practices for protecting my health information. I understand that it is my responsibility to read this document and to ask about anything that is unclear.

_____ _____
(Signature of Patient or Parent if minor) (Date)

_____
(Printed name of Patient)