

Michael R. Lyles, M.D.

Diplomate of the  
American Board of  
Psychiatry and Neurology



Mark E. Crawford, Ph.D.

Licensed Psychologist

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 "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data; the keeping and use of patient records; and storage and access to health records. 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 have already received similar notices such as this one from your other health care providers.

As you might expect, HIPAA laws and regulations are extremely detailed and confusing if one does not have formal legal training. The Notice of Policies and Practices of Lyles & Crawford, P.C. to Protect the Privacy of Your Health Information (located in the waiting room in the frames on the wall) is our attempt to inform you of your rights in a simple and comprehensive fashion. Please read this document as it is important that you know what patient protections HIPAA affords all of us. If you have any questions about any of the issues discussed in this document, please do not hesitate to ask us for clarification.

We are required to obtain your signature indicating that you have reviewed a copy (you may have a copy if you request one) of the Notice of Policies and Practices of Lyles & Crawford, P.C. to Protect the Privacy of Your Health Information 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, and that I may at any time, ask questions about or seek clarification of the matters discussed in this document.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

11111 Houze Road | Suite 320 | Roswell, GA 30076  
(O) 770.993.0051 | (F) 770.993.0052