



Chart #: \_\_\_\_\_

To: All Clients of Preferred EAP

Re: *Health Information Privacy Notice*

The Preferred EAP / LVHN *Health Information Privacy Notice* is posted in our waiting room and is provided to you in order for us to comply with provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

It describes in detail how information about you may be used and disclosed and how you can get access to this information. If you want a pamphlet copy of this *Notice*, please inform the receptionist or your counselor and one will be provided.

Please ask your counselor about any questions you may have concerning your privacy and the confidentiality of your records. Thank you.

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I acknowledge being advised of the *Health Information Privacy Notice*.

Client's Name: (Please print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Name: (Please print) \_\_\_\_\_  
(If client is a child less than 14 years of age)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

EAP Witness Name: \_\_\_\_\_

EAP Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

A copy of this document will be provided to you upon request.