

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT EDUCATION PRIVACY TRAINING ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF PRIVACY TRAINING BY ASSOCIATE/STUDENT/VOLUNTEER/CONTRACTOR

1. I understand that X Company/X Nursing Home has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information.
2. I am aware that, as part of the Organizations' responsibilities described in paragraph 1, above, the Organization provides privacy training to its staff.
3. I acknowledge that I have received privacy training provided by the Organization.
4. I certify that I am familiar with the Organizations' policies and procedures regarding the privacy of health information, and I agree to follow those policies and procedures.
5. I agree to attend future privacy training sessions, as and when requested by the Organization.
6. I further agree that I will report promptly any known or suspected violations of the organization's policies and procedures regarding the privacy of health information to the Organizations' privacy official or his designee.

Print Name: _____

Title/Dept/Location.: _____

Signature: _____ Date: _____
