Employee HIPAA Privacy Training Acknowledgement

I acknowledge that I have completed the company Health Insurance Portability and Accountability (HIPAA) Privacy Rule training program. I understand that HIPAA requires me as an employee of this company to safeguard any Protected Health Information (PHI) that might come into my work area.

I further understand that there are serious consequences for the intentional or unintentional disclosure of PHI and certify by my signature below that I will take every precaution to safeguard such information.

I understand that if my actions contribute to the disclosure of PHI in any way, my employment may be immediately terminated and court actions may involve fines up to $250,000 and up to 10 years in prison.

Employee Signature: _____

Employee Printed Name: _____

Job Description: _____

Employee Start Date: _____

Privacy Rule Training Course Completed on: _____