ACKNOWLEDGMENT OF PRIVACY AND SECURITY POLICIES FOR [PRACTICE NAME] HIPAA PROGRAM

I acknowledge that I have read and understand the Privacy and Security Policies for [Practice Name] HIPAA Program, effective [insert effective date of policy] ("HIPAA Policies").

I understand that, as member of the workforce of [Practice Name], I am expected to comply with the HIPAA Policies. I agree to comply with the HIPAA Policies.

I understand that failure to comply with the HIPAA Policies may result in discipline/sanctions including, but not limited to, termination, suspension, demotion, reduction in pay, reprimand and/or re-training. I further understand that failure to comply with the HIPAA Policies could be grounds for civil or criminal penalties.

Print Name: _____

Signature: _____

Date: _____