



HIPAA Privacy Policy Acknowledgment Form

Employee Information

- Full Name: _____
- Employee ID: _____
- Department: _____
- Supervisor: _____
- Date: _____

HIPAA Privacy Policy Acknowledgment

I acknowledge that I have received, read, and understand the HIPAA Privacy Policy from [Organization Name]. I agree to comply with the privacy and security regulations as outlined by HIPAA (Health Insurance Portability and Accountability Act) to ensure the confidentiality and protection of patient information.

I am aware that non-compliance with the HIPAA policies could result in disciplinary action and/or legal penalties, including termination of employment. I also understand that these policies may be updated and that I will be notified of any changes.

Signature

- Employee Signature: _____
- Date: _____

Witness/HR Representative (if applicable)

- Name: _____
- Signature: _____
- Date: _____