Student/Parent Acknowledgement of Privacy and Security of Patients' Protected Health Information

Name of Practice:

_____

Facility Address:

_____

Name of Student:

_____

Parent/Guardian (if student is a minor):

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Acknowledgement

I understand that the privacy and security of patient information in this practice is of the utmost importance and that I have a responsibility to protect that information in compliance with HIPAA Privacy and Security Rules. I understand that any violations may result in immediate removal from the facility. I also understand that personal cell phone use and personal internet use on facility computers is prohibited.

Signature of Student:

_____

Signature of Parent/Guardian:

_____

Signature of Security Officer:

_____

Date:

_____