



DHH HIPAA PRIVACY TRAINING ACKNOWLEDGEMENT FORM

As a contract employee of the Department of Health and Hospitals (DHH), I,
_____ have reviewed and
understand the DHH HIPAA Privacy Policies and Procedures. I am aware that
violations of the policies and procedures subject me to disciplinary action up to
and including dismissal. I agree to abide by the DHH HIPAA Privacy Guidelines.

Contract Employee Signature

Date