***Practice Name***

HIPAA Training Completion and Confidentiality Form

I, , as a volunteer/student/intern/temporary

 First Name, Last Name

employee of confirm that I:

 Practice Name

* Attended HIPAA compliance training;
* Am committed to maintaining patient confidentiality and complying with HIPAA;
* Will participate in any future training and education when requested by the Practice;
* Understand that it is my responsibility to raise questions or concerns that I may have regarding HIPAA compliance and that failure to report concerns may subject me to disciplinary action; and
* Will not discuss or divulge, directly or indirectly, any confidential patient information with anyone other than the Practice’s designated Privacy Officer or other employee as necessary to carry out patient care, unless such disclosure is otherwise compelled by law or permitted by HIPAA.

Signed:

Date: