**CONFIDENTIALITY ATTESTATION**

I understand that the information I received in error on

 Date

from

 Practice Name (Sender)

contained Protected Health Information (PHI) of another person and the confidentiality of that PHI is protected by the Health Insurance Portability and Accountability Act (HIPAA).

I attest that:

* The PHI has been properly destroyed or returned, and no copies were made or saved.
* I have not and will not use or further disclose any of the information for any purpose.
* I will not discuss the receipt of the PHI with anyone except the Sender.

I have read and agree to comply with the statements listed above.

Signature: Date:

Printed Name:

Company/Organization:

 (If applicable)

Please sign and return this [via fax/mail/scan-email] to:

*Practice Name*

*ATTN:*

*Address*

*Fax*

*Phone*

*Email*