Acknowledgement of HIPAA
Minimum Necessary Criteria & Responsibility Form

I ____**(Please print first and last name)** _____ understand that my role as a member of the workforce and continued role as a member of the workforce is contingent upon compliance with all policies and rules of the Health System. In addition, I understand that I am required to keep confidential patient protected health information. I recognize and acknowledge that during the course of my participation as a member of the workforce, I may become aware of such private and confidential information. I hereby agree to keep this information confidential forever and not to use or disclose it to others, including all members of the Health System's workforce, and its entities and patients and family members, unless there is a need to know and I am otherwise authorized by the Health System, the Health System policies and procedures, the patient (for that patient's specific information) or, where appropriate, as required by law. I understand that I must comply with the Health System's policies and procedures regarding protected health information under HIPAA laws and regulations and I acknowledge that I have been trained in the appropriate uses and disclosures of protected health information as they relate to my specific workforce role.

Level ___5___ Initials _____

NAME: _____
(*Signature*)

Print Name: _____

Date: _____

Have each member of the workforce complete – copy for them and place a copy in employee's Departmental File

If you are completing the form with a student, volunteer, vendor's employee, etc. you may want to complete the following contact information:

Home Address: _____

City, State, Zip: _____

Home Phone Number: _____