The University of Texas at Austin

School of Nursing

HIPAA Supplemental Training for Health Care Settings

Printed Name **UT EID**

I have completed this HIPAA training program. I understand the basic provisions of the law and agree to do my part to ensure the patients' rights of privacy and confidentiality. Furthermore, I understand the consequences of failing to do so.

Signature **Date**

Please save the completed form on your computer. Upload the completed document to your file on Certified Background.