

Attachment H

THE UNIVERSITY
OF
ALABAMA

**HIPAA PRIVACY RULE
ACKNOWLEDGEMENT OF
UNDERSTANDING**

I have attended The University of Alabama's training session on the requirements for ensuring the privacy of patients' protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

I understand what protected health information is, and have been informed of the civil and criminal penalties for unauthorized disclosure of protected health information.

I understand that I am responsible for keeping protected health information from unauthorized disclosure, alteration, or destruction and that I will not share any patient's protected health information with anyone who is not engaged in treatment, payment, or healthcare operations, unless authorized by the Privacy Officer in my organization. I also agree that I will not access any patient's protected health information unless I have a legitimate job-related need to know and such access is consistent with my department's policies and procedures.

I understand that my failure to abide by my department's policies and procedures related to confidentiality of health information could expose me to job-related disciplinary sanctions, up to and including termination of my employment.

Signature: _____

Printed Name: _____

Date: _____ SS #: _____

University Department: _____

This form should be returned to your Department's Privacy Officer for retention.

Effective Date: March 17, 2003