Troy University School of Nursing
HIPAA
Acknowledgement of Understanding

I have participated in a 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, and that I will not share any patient's or client's protected health information with anyone who is not engaged in treatment, payment, or healthcare operations, unless authorized by the Privacy Officer in the organization where I am assigned. I also agree that I will not access any patient's protected health information unless I have a legitimate need to know that is related to my assignment.

I understand that I am responsible for learning the particular policies and procedures of the clinical agency where I have been placed. I also understand that I am subject to the sanctions those clinical agencies may impose for a breach of confidentiality. I also understand that my failure to abide by the agency's policies and procedures related to confidentiality of protected health information and could result in a variety of academic and/or disciplinary sanctions, up to and including dismissal from my academic program.

Signature: _____

Print Name: _____

Date of Training Session: _____

Program: ____ MSN ___DNP