SOUTHWELL

VERIFICATION OF HIPAA

I have received instructions on maintaining HIPAA PRIVACY.

I have been informed about the importance of patient confidentiality and the requirements of the HIPAA legislation. I have had an opportunity to ask questions and have received answers to those questions regarding the above information. I understand the importance of this information related to my participation in activities of the hospital.

As a shadowing participate with Tift Regional Health System, Inc., I agree to comply with the guidelines addressed in the HIPAA training.

_____

Print name

_____

Signature **Date**

_____

(Parent/Legal Guardian) Print name

_____

(Parent/Legal Guardian) Signature **Date**