ALABAMA DEPARTMENT OF PUBLIC HEALTH (ADPH)
HIPAA PRIVACY AND SECURITY
ACKNOWLEDGEMENT OF COMPLETION
DEPARTMENTAL POLICY & TRAINING

I certify that I have received a copy of the most current **ADPH HIPAA Privacy and Security Policy and completed the most current ADPH HIPAA Privacy and Security Training**. Any questions that I have with regard to the policy or training have been answered. I understand how HIPAA relates to me as a nursing student/volunteer/intern of ADPH. I also understand that if I have future questions concerning HIPAA in my work as a nursing student/volunteer/intern I may contact the ADPH HIPAA Privacy and Security Officers.

By signing this document, I acknowledge completion of the most current ADPH HIPAA Privacy and Security Training and review of the most current HIPAA Privacy and Security Policy.

Student/Volunteer/Intern Name (Print): _____ Date: _____

Student/Volunteer/Intern's Signature: _____

Preceptor/Clinic Supervisor Name (Print): _____ Date: _____

Preceptor/Clinic Supervisor's Signature: _____