

The University  
Of  
ALABAMA

HIPAA PRIVACY AND SECURITY  
HITECH BREACH NOTIFICATION  
ACKNOWLEDGEMENT OF  
UNDERSTANDING

I have completed The University of Alabama training session on the security and privacy requirements for protecting the confidentiality, integrity, and availability of patients' protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) and on breach notification requirements under HITECH.

I have been trained on what PHI is, and have been informed of the civil and criminal penalties for unauthorized access, use, disclosure, modification or destruction of PHI and of the civil penalties that may be imposed for violations of the HIPAA privacy and /or security and/or breach notification rules. I understand that I am responsible for protecting PHI from unauthorized disclosure, alteration, or destruction, and that I am not permitted to share any patient's PHI with anyone who is not engaged in treatment, payment, or health care operations, unless authorized by the Privacy Officer. I also agree that I will not access any patient's PHI 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 I will receive periodic reminders of our security safeguards, and that I am responsible for reviewing and complying with those reminders. I have been trained that it is my responsibility to follow guidance provided to me to protect against malicious software and to report any signs of malicious software activity in my work environment. I am aware that log-in activity is being monitored and I will report any suspicious activity associated with unusual login attempts. I have been trained on the importance of proper passwords and proper use of workstations. I also have been trained that computer disk, CD Rom, DVD, and any other removable storage devices must be properly cleaned and erased before transfer, reuse, or disposal. I agree to immediately report all suspected or known breaches of confidentiality and/or security incidents.

I understand that my failure to abide by any of my department's HIPAA privacy and security and breach notification policies and procedures could expose me to job-related disciplinary sanctions, up to and including termination of my employment.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_ CWID #: \_\_\_\_\_

University Department: \_\_\_\_\_

*This form should be returned to your Department's Privacy and/or Security Officer(s) for retention. Original effective date: March 17, 2003; revised 6/29/2011; 11/01/2014*