Employee Statement of Understanding of Privacy Policies

Department of Elder Affairs
4040 Esplanade Way
Tallahassee, FL 32399-7000
(850) 414-2000

I, _____, have been trained and informed about the business and privacy practices in affect at **DOEA** as a result of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that I am responsible for ensuring the security, integrity and confidentiality of patient health information created, obtained and/or maintained by **DOEA**.

I have reviewed, understand, and agree to abide by the following Privacy Policies:

I. CONSUMER'S PRIVACY RIGHTS POLICY
II. NOTICE OF PRIVACY PRACTICES
III. BUSINESS ASSOCIATES
IV. RESPONSIBILITIES OF COVERED ENTITIES.
V. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
VI. DISCLOSURE TRACKING POLICY
VII. MINIMUM NECESSARY REQUIREMENTS
VIII. INDIVIDUAL RIGHTS TO PROTECTED HEALTH INFORMATION
IX. ADMINISTRATIVE REQUIREMENTS STANDARDS
X. DOEA GENERAL INFORMATION SYSTEMS ACCESS POLICY
XI. CHANGES TO POLICIES & PROCEDURE
XII. COMPLAINTS

I understand that non-compliance will be cause for disciplinary action up to and including dismissal from **DOEA**, and possible legal actions for violations of applicable regulations and laws.

I agree to promptly report all violations or suspected violations of any of the above policies to **DOEA's** Privacy Officer through the designated reporting channels.

_____
Print Employee Name

_____ _____
Employee Signature Date

_____ _____
DOEA Signature Date