HIPAA Sign-In Form

The Application of HIPAA to ADPH Employees and Our Patients

I certify that I have viewed the training program "The Application of HIPAA to ADPH Employees and Our Patients". I further certify that I understand my job responsibilities in complying with HIPAA requirements.

SIGN NAME:_____

PRINT NAME:_____

SOCIAL SECURITY NUMBER:_____

OFFICE/BUREAU/AREA/COUNTY: _____

DATE: _____