GEORGIA PERIMETER COLLEGE

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

HIPAA TRAINING VERIFICATION FORM

I have received the Health Insurance Portability and Accountability Act (HIPAA) training or information. The training was conducted or the information was give to me on ____________ (date).

_____ I am a Georgia Perimeter College employee.

_____ I am a Georgia Perimeter College student.

As a Georgia Perimeter College employee or student, I may access and disclose of protected healthcare information (PHI) for payment, treatment or healthcare operations (PTO). I understand that PHI is confidential and that authorization from the employee must be obtained to use or disclose PHI that is requested for reasons other than treatment, payment or operations, or in order to comply with the law.

The college fully supports and complies with all federal and state statutes and rules regarding the use, maintenance, transfer and disposition of health records and information. I understand that violation of HIPAA Privacy Rule may result in disciplinary action up to and including termination of employment or expulsion from school.

_________________________  ____________________________
Signature                  Print Name

_________________________  ____________________________
Department                 Campus

_________________________
Date