SCHENECTADY COUNTY COMMUNITY COLLEGE
POLICY AND PROCEDURE
2.3.1 (Employee Signature)

SUBJECT: Confidentiality of Health Information Signature Form

Employee Name:____
Position Title:____
Supervisor Name & Title:____

The Health Information Portability and Accountability Act of 1996 (HIPAA) requires that all covered entities have in place a process to ensure compliance with the mandated requirements and that monitoring of compliance occur on an annual basis. The Schenectady County Community College Policy and Procedure for Confidentiality of Health Information ensures the privacy of health information.

By signing this statement I am affirming that:

1. I have been provided with a copy of the Schenectady County Community College Policy and Procedure for Confidentiality of Health Information; and

2. I understand that health information is strictly confidential and will never be disclosed, nor confirmed to anyone who is not specifically authorized under the College's policies or applicable law to receive the information; and

3. I agree to appropriately inform the staff I supervise of this policy and procedure.

Signature: ____

Date: ____

Signed form to be returned to the Office of Human Resources