SPANISH PEAKS REGIONAL HEALTH CENTER

CONFIDENTIALITY ACKNOWLEDGEMENT

I, _____, have been given an overview of the Health Insurance Portability & Accountability Act (HIPAA) Privacy Standards. I certify to keep all information I see/hear during my visit to Spanish Peaks Regional Health Center confidential and private, and understand I could face criminal charges for violating the HIPAA Privacy Standards by disclosing or discussing information about a patient or resident at the facility to anyone outside the facility, or to anyone who is not deemed to have a "need to know", which includes current employees of the facility.

Print Name: _____

Signature and Date: _____ _____