Belmont College Medical Assisting Program Student Understanding of HIPAA

HIPAA (Health Insurance Portability and Accountability Act) Training

I confirm that I have received HIPAA training and agree to follow the guidelines set forth.

I understand that this signed statement will be in effect for the duration of the Medical Assisting Program. I understand that violations of HIPAA will result in disciplinary measures up to and including removal from the Medical Assisting program.

Student Signature:

_____

Printed Name:

_____

Date:

_____