



## Employee Statement of Understanding of Privacy Policies

I, \_\_\_\_\_, have been trained and informed about the business and privacy practices in affect at ENT and Allergy Associates, LLP as a result of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that I am responsible for ensuring the security, integrity and confidentiality of patient health information created, obtained and/or maintained by ENT and Allergy Associates, LLP. I have reviewed, understand, and agree to abide by the privacy policies including the policies relating to the use, collection, disclosure, storage and destruction of personal health information.

I understand that non-compliance will be cause for disciplinary action up to and including dismissal from ENT and Allergy Associates, LLP and possible legal actions for violations of applicable regulations and laws.

I agree to promptly report all violations or suspected violations of any of the above policies to ENT and Allergy Associates, LLP's Privacy Officer through the designated reporting channels.

\_\_\_\_\_  
Print Employee Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date