South Dakota Department of Human Services

Privacy Program
Statement of Understanding

I, _____, have been trained and informed about the business practice in DHS as a result of the Health Insurance Portability and Accountability Act (HIPAA). I understand that I must ensure the privacy of DHS clients/patients or participant's information obtained and held by DHS.

I have reviewed, understand, and agree to abide by DHS Privacy Policies and Procedures.

I understand that non-compliance will be cause for disciplinary action up to and including termination from DHS, 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 the HIPAA Privacy Office through the designated reporting channels.

_____ _____

Print Employee/Volunteer Name Employee/Volunteer Signature Date

_____

Supervisor Signature Date

☛ **To be filed in employee's personnel or volunteer's file.**

This form is available in alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA).
Contact DHS at: Phone (605) 773-5990 or Fax (605) 773-5483

Copy to personnel or volunteers file
Cc copy to DHS Office of Legal Counsel