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**CONFIRMATION OF HIPAA TRAINING**

**DATE OF ACTIVITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF PARTICIPANT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACTIVITY SUMMARY: Read MedScribe HIPAA Policy and procedures article.**

**STATEMENT OF PARTICIPATION: *This confirms that I participated in the above HIPAA training on this date, and understood the information covered within this activity.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Participant**

**(if form is sent via email, include employee ID# following signature)**