Clark County, Wisconsin
Title: HIPAA Policy/Procedure Training Acknowledgment

Name of Policy/Procedure	
Policy/Procedure Effective Date	
Policy/Procedure Revision Date	
Date(s) of Policy/Procedure Training	

I acknowledge that I have received, read, reviewed, and understand the policy/procedure listed above. I understand that it is my responsibility to comply with Clark County's policies and procedures. I further understand that if I do not comply with Clark County's policies and procedures, I may be subject to corrective action and/or discipline including, but not limited to, termination.

If I have questions about Clark County's policies and procedures, I understand it is my responsibility to seek clarification from my supervisor or department head.

Employee Number	
Employee Name	
Employee Signature	
Date	
Department	
Supervisor/Department Head Name	
Supervisor/Department Head Signature	
Date	