

**ACKNOWLEDGMENT OF HIPAA SECURITY AWARENESS
And
AGREEMENT TO COMPLY
FOR MEDICAL STAFF, RESIDENT STAFF AND OTHER
CREDENTIALLED PRACTITIONERS**

I am, or in the future may become, a user of one or more Johns Hopkins information technology devices or systems that may include Electronic Protected Health Information ("E-PHI"). I hereby certify that:

1. I have reviewed the "Johns Hopkins HIPAA Security Awareness" handout and the "Johns Hopkins Computer Security Tips" handout.
2. I recognize the importance of maintaining the confidentiality and integrity of the E-PHI that I work with for my job duties.
3. I agree to abide by Johns Hopkins policies and procedures as explained in the Johns Hopkins HIPAA Security Awareness handout.

Witness my signature as of the date set forth below.

Signature

Printed Name

Date

Copy of this completed form will be maintained in the practitioner's credentials file.

Return this form to:
Medical Staff Administration
Johns Hopkins Medicine
Billings Administration, Room 328
600 North Wolfe Street
Baltimore MD 21287

Or via fax to : (410) 955-4810