Saint Louis University
School of Nursing

HIPAA Training

Receipt and Acknowledgement

My signature below acknowledges that I:

- Have accessesd the HIPAA information, "Overview of HIPAA," on (date)_____.
- Have listened to and do understand the information provided.
- Will contact my professor and/or the appropriate agency representative if I have questions and/or concerns about HIPAA adherence.
- Am responsible for following these HIPAA guidelines when participating in any experiences with clients.

_____ _____

Student signature Option (MSN or PM and Specialty)

_____ _____

Student Name (printed) Student ID (Banner #)

_____

Date

You must complete, sign and return this form to:

Office of Student Services
Saint Louis University School of Nursing
3525 Caroline Mall
St. Louis, MO 63104-1099

Fax: 314-977-8949

Email: kolbm@slu.edu