SAN MATEO HEALTH SYSTEM
BEHAVIORAL HEALTH AND RECOVERY SERVICES

ACKNOWLEDGEMENT OF RECEIPT

I, _____ _____
(print name) *(print title)*

of _____ hereby acknowledge that on this date I received
(print name of department)

and read, the Mental Health HIPAA Policies listed below.

(Place your initials to the right of each individual policy to indicate that you received and read that policy.)

Behavioral Health Confidentiality Policies:	**Initials:**
1. Policy 00-06 Client Access to Protected Health Information	_____
2. Policy 03-01 Confidentiality/Privacy of Protected Health Information	_____
3. Policy 03-11 E-Mail Use	_____
4. The BHRS Compliance Plan	_____
5. The BHRS Code of Conduct	_____
6. Compliance with Documentation Standards	_____

Clinical Staff Only

4. Policy 03-02 Notice of Privacy Practices	_____
5. Policy 03-04 Disclosure of Protected Health Information, Minimum Necessary	_____
6. Policy 03-05 Disclosure of Protected Health Information, Incidental	_____
7. Policy 03-06 Disclosure of Protected Health Information with Client Authorization	_____
8. Policy 03-07 Disclosure of Protected Health Information, Request for an Accounting	_____
9. Policy 03-08 Restrictions on Use or Disclosure of Protected Health Information Client Request	_____
10. Policy 03-09 Amendment of Protected Health Information, Client Request	_____

By signing I also acknowledge my responsibility to abide by these policies.

Signature _____ Date _____