SAN MATEO HEALTH SYSTEM  
BEHAVIORAL HEALTH AND RECOVERY SERVICES  

ACKNOWLEDGEMENT OF RECEIPT

I,  
(print name)  
(print title)  
of  
(print name of department)  hereby acknowledge that on this date I received 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:**

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 ____________________