***ACKNOWLEDGEMENT STATEMENT***

***THE RIVERSIDE HEALTH HIPAA TRAINING***

***FUTURE PHYSICIAN LEADERS PROGRAM***

My signature on this form acknowledges that I have completed the UC Riverside Health HIPAA Privacy and Security Training Module and I agree to abide by UC Riverside Health HIPAA Privacy and Security Compliance requirements.

Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_