# ORGANIZATIONAL INTEGRITY PROGRAM

**AND HIPAA ACKNOWLEDGMENT**

**VOLUNTEER SERVICES**

By signing this form, I acknowledge that I have:

* Carefully read the following pages regarding “HIPPA.”

As a volunteer of Trinity Health Oakland, I understand that I am expected to protect the confidential health information of patients. I also understand that I am expected to seek answers from a Senior Leader to questions or concerns that may arise that include possible violation of law, regulations, policies and procedures or the Standards of Conduct.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please return this form to the Volunteer Services Department. Thank you.