

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:**

**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 \_\_\_\_\_