

**SUNY Upstate Medical University  
HIPAA Privacy and Security Education  
Completion Certificate**

By signing below, I acknowledge that I have been provided education on the HIPAA Privacy Rule and HIPAA Security Rule and SUNY Upstate Medical University's Privacy Practices. I understand that if I have any questions, I should contact the Institutional Privacy Office at 464-6135.

Name: \_\_\_\_\_  
(Please Print)

Employee ID: \_\_\_\_\_

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

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

Self Serve Tracker Code: HIPAA-H

REV: 4/2016, OTD