Ave Maria University Employee Health Plan

HIPAA PRIVACY PRACTICES

NOTICE OF RECEIPT

(Completion of this form is required)

Employee Name: _____

(Please print)

My signature below acknowledges receipt of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice that was provided to me by employer, Ave Maria University.

Employee Signature: _____

Date: _____

Privacy Officer Signature: _____

Date: _____

Please return the signed form to the Human Resources Office via email to: HR@avemaria.edu, or via fax to: 239-280-2492