

**SUNY Upstate Medical University
Privacy Education Completion Certificate**

By signing below, I acknowledge that I have been provided education on the HIPAA Privacy 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: _____