

HIPAA TRAINING ATTESTATION

Name (please print): _____

Agency Affiliation/Job Title: _____

My signature below indicates that (check all):

- I have reviewed the HIPAA self-study training on
____/____/_____.
- I have passed (scored 80% or higher) the HIPAA test on
____/____/_____.
- I have reviewed and understand the St. Clair County Community Mental Health
Policy #08-002-0006 *Health Care Information – Privacy & Security Measures*
____/____/_____.
- I have reviewed and understand the St. Clair County Community Mental Health
Policy #08-002-0005 *Protected Health Information – Privacy Measures* on
____/____/_____.
- I have reviewed and understand the St. Clair County Community Mental Health
Policy #08-001-0010 *Computer Information Systems Security* on
____/____/_____.
- I understand that if I have any questions regarding the training subject matter, I
may contact the St. Clair County Community Mental Health Training
Department for clarification.

Signature: _____ Date: _____

Upon completion of this training, please forward this training attestation to your
organization's human resources/training representative.



3111 Electric Avenue
Port Huron, MI 48060
Phone: 810-985-8900