

HIPAA Training Acknowledgment/Certification

I, _____, hereby certify that, on the date of my signature below, I have attended the training session regarding HIPAA Privacy and protected health information and have received the procedures for my office for HIPAA compliance in administering the state group health plans. I understand that it is my responsibility to read and comply with these policies and to follow the procedures outlined in the policies and today's training. I hereby certify that I will protect the privacy of the protected health information related to the state group health plans.

Signature

Date