

Community Mental Health and Substance Abuse Services of St. Joseph County

HIPAA Training Attestation

I, _____, acknowledge that I have received and read the required HIPAA training. I agree to comply with the standards that were discussed in the training and any of the Community Mental Health and Substance Abuse Services of St. Joseph County's policies and procedures regarding HIPAA.

Signature

Date

Employer other than CMHSAS of SJC

Please note it is your responsibility to retain documentation proof of your trainings.