

CITY OF MADISON

CERTIFICATION OF TRAINING AND AGREEMENT OF COMPLIANCE

I certify that:

1. I have viewed the City of Madison educational training session regarding compliance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and related State law confidentiality requirements, and have been offered a copy of the City’s HIPAA Confidentiality Policy and Procedure Manual.
2. During the training session, I was instructed on the City’s HIPAA Confidentiality Policy and Procedure manual. This manual outlines the policies and procedures regarding protected health information (PHI), HIPAA, and applicable state law as determined by the City to be necessary and appropriate for me to carry out my specific job responsibilities for the City. I had the opportunity to ask my supervisor and/or the Privacy Officer questions regarding the City's policies and procedures regarding HIPAA. My questions have been answered to my satisfaction. In the event any further questions or concerns about HIPAA should arise, I agree to contact the Privacy Officer or my Supervisor to discuss such issues.
3. I agree specifically to act in accordance with the policies and procedures of the City regarding HIPAA as outlined in training video and the policy manual. I understand that I may be subject to disciplinary action for violating these policies or failing to report any violation of these policies.

Signature: _____

Print Name: _____

Position: _____

Date: _____

Duplicate Form to be maintained by: Privacy Officer/HIPAA Compliance Files

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HIPAAcertTrainingAgmt.doc