

**Barry County Community Mental Health Authority**

**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 Barry County Community Mental Health Authority's policies and procedures regarding HIPAA.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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