



University of Connecticut
Health Center

Please read and then print and sign your name below. Send the signed form to:

Barbara Case

Dept. of Community Medicine, MC 6325
270 Farmington Avenue
Farmington, CT 06030-6325

**Certification of HIPAA Privacy
Training Packet Completion
Academic Year 2009-2010**

I have read and understand the University of Connecticut Health Center HIPAA Privacy training materials. Further, I understand that the location of additional information about UCHC's policies and procedures related to patient privacy have been detailed in the training documents.

Printed Name _____

Class of _____

Medical Student

Dental Student

Graduate Student

Signature _____

Date _____