



Concise and API Training – Participant Attestation

The purpose of this document is to 1) identify the individual at the _____ who is responsible for managing training requirements and 2) certify that such training meets Healthix policy and privacy requirements 3) limit Access to any Protected Health Information obtained through the Certified Application to individual users of the _____ information system who would be eligible to be Authorized Users of the Participant under these Policies and Procedures if they were Accessing Protected Health Information directly through Healthix.

Please provide the following information:

Name	
Title	
Email	
Phone #	

ACKNOWLEDGEMENT

I hereby acknowledge and agree that I am responsible for the management of training for Authorized Users of _____ prior to allowing access to information obtained from Healthix via the Certified Application. I will work with Healthix to educate Authorized Users about the policies and procedures for Accessing Protected Health Information via the SHIN-NY governed by Healthix as specified by the Statewide Collaboration Process. I am aware that Healthix has provided training materials for me to access via <https://healthix.org/ca-training/>.

I also will ensure that each Authorized User signs a certification that he or she has received training and will comply with Healthix policies and procedures. Such certification may be made on a paper form or electronically and shall be retained by _____ for at least six years. I will also ensure that each Authorized User undergoes continuing and/or refresher training on an annual basis as a condition of maintaining authorization to Access patient information via the SHIN-NY governed by Healthix.

If any of the personal information I have provided on this document changes I will inform Healthix immediately. If at any point in time the _____ wishes to change the individual responsible for the implementation of the Certified Application Training, I will ensure that Healthix is notified and receives a new Certified Application Participant Attestation Form by email to compliance@healthix.org. I understand that until this occurs, I will remain responsible for training of Authorized Users via the Certified Application.

Date

Signature

To be completed by Healthix staff:

CERTIFICATION

Healthix hereby certifies that all security and privacy requirements for access to Healthix through a Certified Application have been communicated to and validated by the _____

Compliance Manager

Signature