Business Associate Acknowledgement

HIPAA and Patient Privacy Compliance

Purpose:

This form outlines the expectations and responsibilities of non-employees (business associates) who provide services to or on behalf of Karla R. McDonald DDS, LLC, and may have access to Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act (HIPAA).

Business Associate Information:

Associate Name: _____ Company:_____
Address: _____
Phone: _____ Email: _____

Acknowledgment of Responsibilities

As a business associate of Karla R. McDonald DDS, LLC, I understand and agree to the following:

1. **Confidentiality of PHI**
   - I may have access to PHI in the course of providing services. I agree to keep this information strictly confidential and to use or disclose PHI only as necessary to perform my duties and only as permitted by HIPAA and applicable laws.

2. **HIPAA Compliance**
   - I acknowledge that I must comply with HIPAA regulations, including administrative, physical, and technical safeguards to protect PHI's confidentiality, integrity, and availability.

3. **Security Measures**
   - I will use secure methods when transmitting, storing, or disposing of PHI. I will not leave patient information unattended or accessible to unauthorized individuals.

4. **Reporting Breaches**
   - I will immediately report any suspected or actual breach of PHI, unauthorized disclosure, or HIPAA violation to the designated HIPAA Privacy Officer at Karla R. McDonald DDS, LLC upon discovery.

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5. **No Retention of PHI**
   - I will not retain any copies of PHI once the business relationship ends, unless expressly permitted in writing.

6. **Return or Destruction of PHI**
   - **Upon** termination of services, I agree to return or securely destroy any PHI in my possession, unless otherwise required by law.

7. **Training and Understanding**
   - I affirm that I have received appropriate HIPAA training or have been informed of the policies and procedures related to the protection of patient privacy as required for my role.

Signature & Agreement

By signing below, I acknowledge that I understand and agree to comply with the privacy and security policies of Karla R. McDonald DDS, LLC and with HIPAA regulations. I understand that failure to comply may result in termination of my services and legal consequences.

Signature: _____
Printed Name:_____
Date: _____
Authorized Representative (if signing for a company):_____

This description is meant to be a general guideline of Privacy and HIPAA expectations; management reserves the right to address additional requirments based on services provided.

Karla R. McDonald DDS, LLC Representative:_____

Date Reviewed and initials: _____

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