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**Medical Collaboration Agreement**

This Privacy Agreement ("Agreement"), is effective upon signing this Agreement and is entered

into by and between ***Name of Agency*** ("Covered Entity") and **Name of Hospital** (the "Business Associate").

1. **Term**. This Agreement shall remain in effect for the duration of this Agreement and shall

apply to all of the Services and/or Supplies delivered by the Business Associate pursuant to this

Agreement.

2. **HIPAA Assurances**. In the event Covered Entity and/or Business Associate creates, receives, maintains, or otherwise is exposed to personally identifiable or aggregate patient or other medical information defined as Protected Health Information ("PHI") in the Health Insurance Portability and Accountability Act of 1996 or its relevant regulations ("HIPAA") and otherwise meets the definition of Business Associate as defined in the HIPAA Privacy Standards (45 CFR Parts 160and 164), Business Associate and/or Covered Entity shall:

(a) Recognize that HITECH (the Health Information Technology for Economic and

Clinical Health Act of 2009) and the regulations thereunder (including 45 C.F.R. Sections

164.308, 164.310, 164.312, and 164.316), apply to a business associate and/or covered entity in the same manner that such sections apply;

(b) Not use or further disclose the PHI, except as permitted by law;

(d) Use appropriate safeguards (including implementing administrative, physical, and

technical safeguards for electronic PHI) to protect the confidentiality, integrity, and

availability of and to prevent the use or disclosure of the PHI other than as provided for

by this Agreement;

(e) Comply with each applicable requirements of 45 C.F.R. Part 162 if the Business

Associate conducts Standard Transactions for or on behalf of the Covered Entity and/or Business Associate;

(f) Report promptly to any security incident or other use or disclosure of PHI not provided for by this Agreement of which Business Associate and/or Covered Entity becomes aware;

(g) Ensure that any subcontractors or agents who receive or are exposed to PHI (whether

in electronic or other format) are explained the Covered Entity and/or Business Associate obligations under this paragraph and agree to the same restrictions and conditions;

(h) Make available PHI in accordance with the individual’s rights as required under the

HIPAA regulations;

3. **Termination Upon Breach of Provisions**. Notwithstanding any other provision of this

Agreement, Business Associate may immediately terminate this Agreement if it determines that

Business Associate breaches any term in this Agreement. Alternatively, Covered Entity may give

written notice to Business Associate in the event of a breach and give Business Associate five (5)

business days to cure such breach. Covered Entity shall also have the option to immediately stop

all further disclosures of PHI to Business Associate if Covered Entity reasonably determines that

Business Associate has breached its obligations under this Agreement. In the event that

termination of this Agreement and the Agreement is not feasible, Business Associate hereby

acknowledges that the Covered Entity shall be required to report the breach to the Secretary of

the U.S. Department of Health and Human Services, notwithstanding any other provision of this

Agreement or Agreement to the contrary.

4. **Return or Destruction of Protected Health Information upon Termination**. Upon the

termination of this Agreement, unless otherwise directed by Covered Entity, Business Associate

shall either return or destroy all PHI received from the Covered Entity or created or received by

Business Associate on behalf of the Covered Entity in which Business Associate maintains in

any form. Business Associate shall not retain any copies of such PHI. Notwithstanding the

foregoing, in the event that Business Associate determines that returning or destroying the

Protected Health Information is infeasible upon termination of this Agreement, Business

Associate shall provide to Covered Entity notification of the condition that makes return or

destruction infeasible. To the extent that it is not feasible for Business Associate to return or

destroy such PHI, the terms and provisions of this Agreement shall survive such termination or

expiration and such PHI shall be used or disclosed solely as permitted by law for so long as

Business Associate maintains such Protected Health Information.

5. **No Third Party Beneficiaries**. The parties agree that the terms of this Agreement shall apply

only to themselves and are not for the benefit of any third party beneficiaries.

6. **De-Identified Data**. Notwithstanding the provisions of this Agreement, Business Associate

and its subcontractors may disclose non-personally identifiable information provided that the

disclosed information does not include a key or other mechanism that would enable the

information to be identified.

7. **Amendment.** Business Associate and Covered Entity agree to amend this Agreement to the

extent necessary to allow either party to comply with the Privacy Standards, the Standards for

Electronic Transactions, the Security Standards, or other relevant state or federal laws or

regulations created or amended to protect the privacy of patient information. All such

amendments shall be made in a writing signed by both parties.

8. **Interpretation**. Any ambiguity in this Agreement shall be resolved in favor of a meaning that

permits Covered Entity to comply with the then most current version of HIPAA and the HIPAA

privacy regulations.

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***Name of Agency*: Name of Doctor, Practice or Hospital:**

Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Name of Your Agreement Here** |

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| **Name of Partner Here** **Address****City State Zip code** | **Work Phone:**  |
| **Other Phone:**  |
| **Fax Number:**  |

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| --- | --- | --- | --- |
| **Provider Name & Phone Number** |  |  **Patient Name & Address & Phone Number** |  |
| **Age** |  | **DOB** |  | **Insurance**  |  |

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| ***Write necessary collaborating info here…*** |

Patient Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_