[Covered Entity Name]

[Covered Entity Contact Name]

[Covered Entity Title]

[Covered Entity Address]

[Date]

[Business Associate Name]

[Business Associate Contact Name]

[Business Associate Title]

Dear [Business Associate Contact First Name],

[Covered Entity Name] is serious about protecting patient information and ensuring that appropriate security measures are in place to comply with the Health Insurance Portability and Accountability Act (HIPAA) regulations. As a Business Associate of [Covered Entity Name] we would like to ensure that [Business Associate Name] is protecting and safeguarding patient information with the same diligence as[Covered Entity Name]**.**

**What is a Business Associate?**A “Business Associate” is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity.

**What the HITECH Act did for Business Associates?**The Health Information Technology for Economic and Clinical Health Act (HITECH Act) is part of the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA contains incentives related to health care information technology in general (e.g. creation of a national health care infrastructure) and contains specific incentives designed to accelerate the adoption of electronic health record (EHR/EMR) systems among providers.

Under the HITECH Act, Business Associates are now required to comply with the safeguards contained in the HIPAA Security Rule and use and disclosure provisions of the HIPAA Privacy Rule.

**Compliance verification**We are respectfully asking you to complete the below section and answer the questions regarding how [Business Associate Name] is currently protecting electronic protected health information and complying with the HIPAA and HITECH regulations. We would appreciate your response on or before [Date of Questionnaire to be Returned].

**Please fill in the following information and answer the following questions:**

Organization’s name: [Business Associate Name]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of organization’s HIPAA security officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization’s Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization’s Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization’s Address: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your organization have a HIPAA security officer? If yes, please fill in above section.

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** | **OTHER** |
|  |  |  |

Has the HIPAA security officer gone through formal HIPAA training?

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** | **OTHER** |
|  |  |  |

Have you performed a Risk Assessment on how the organization is protecting electronic protected health information in the past year?

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** | **OTHER** |
|  |  |  |

Name of organization that performed the Risk Assessment? If the Risk Assessment was performed internally, please put “Internal Risk Assessment” below.

|  |
| --- |
|  |

Do you have HIPAA Policies and Procedures?

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** | **OTHER** |
|  |  |  |

Have your employees been informed about your HIPAA policies?

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** | **OTHER** |
|  |  |  |

Have your employees been trained on HIPAA security in the past year? (This includes, full and part-time employees, contractors, temporary employees, etc)

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** | **OTHER** |
|  |  |  |

Do you use encryption to protect electronic protected health information?

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** | **OTHER**  |
|  |  |  |

Do you have a documented data backup plan?

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** | **OTHER**  |
|  |  |  |

**Organization’s compliance officer signature:**

Name [Print]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Sincerely;

[Covered Entity Contact Signature]

[Covered Entity Contact Name]

[Covered Entity Name]

[Covered Entity Contact Title]