**[\*\*FOR USE ONLY WHEN USING BUSINESS ASSOCIATE AGREEMENT PREPARED BY COVERED ENTITY \*\*]**

**ADDENDUM TO BUSINESS ASSOCIATE AGREEMENT**

ABRET Neurodiagnostic Credentialing and Accreditation, Inc. (“ABRET” or “Business Associate”) and

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Name of Laboratory or Candidate Employer)**  (“Covered Entity”) agree to amend the terms of the Business Associate Agreement as outlined below:

1. **Disclosure to Reviewers**. Covered Entity agrees in advance that Business Associate may disclose PHI to its subcontractor reviewers as part of its accreditation or certification process and for the proper management and administration of Business Associate as long as all such subcontractors agree to the same or similar terms and conditions as agreed to by Business Associate contained in the Business Associate Agreement.
2. **Accounting of Disclosure**s. If Covered Entity informs Business Associate that Covered Entity has received a request for any accounting of disclosures, Covered Entity shall allow Business Associate at least ten (10) business days to make available to Covered Entity such information as is in its possession and is required as to make the accounting required by 45 C.F.R. 164.528.
3. **Notice of Unauthorized Disclosures**. If Business Associate becomes aware of a non-permitted use or disclosure of PHI, Business Associate shall inform Covered Entity in writing within ten (10) business days after Business Associate learns of the use/disclosure.
4. **Disclosure Request Response Procedure**. If Business Associate receives a PHI disclosure request as part of a legal process (by oral questions, interrogatories, requests for information or documents in legal proceedings, subpoena, civil investigative demand, or other similar process), Business Associate shall take the following steps prior to disclosure: (i) assert the confidential nature of the PHI; (ii) send Covered Entity a copy of the request within five (5) business days after Business Associate’s receipt of the request; and (iii) cooperate fully with Covered Entity in obtaining a protective order or other appropriate remedy.
5. **Effect of Termination**. If for any reason, PHI cannot be returned or destroyed upon termination, then all obligations of Business Associate regarding such information shall survive the termination of the Business Associate Agreement indefinitely or until such information is returned to the Covered Entity or destroyed.
6. **Privileged and Confidential Information**. Business Associate is not required to disclose the identity of its application reviewers, application reviewers’ or site visit representatives’ notes regarding the review process, and any other privileged or confidential information unless compelled by court order.
7. **Indemnification**. The indemnification obligations of the Business Associate extend only to claims, liabilities, damages, and/or expenses arising out of a breach of the Business Associate Agreement by the Business Associate.
8. **Red Flags Rules**. Business Associate is not required to implement an identity theft protection program. The Red Flag Rules set forth at 16 CFR §681.2 et seq. are not applicable to Business Associate by virtue of this transaction because Business Associate will not provide services in connection with an account maintained by the Covered Entity that permits patients to make multiple payments for services rendered.
9. **Conflict**. Except as modified by this Addendum, the provisions of the Business Associate Agreement remain in full force and effect. If a provision of this Addendum conflicts with a provision in the Business Associate Agreement, the provision of this Addendum will control.

IN WITNESS WHEREOF, the parties have executed this Addendum to the Business Associate Agreement by their duly authorized representatives effective as of the date of signature by ABRET.

|  |  |
| --- | --- |
| **ABRET Neurodiagnostic Credentialing and Accreditation, Inc.** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **(Covered Entity’s Full Legal Name)** |
| By: | By: |
| Name: | Name: |
| Title: | Title: |
| Date: | Date: |