Business Associate Understanding

Between Ability!, LLC and Transformations, LLC

I, the undersigned, will treat Protected Health Information found within the shared office space of Ability!, LLC and Transformations, LLC in a manner that is confidential and in accordance with the Business Associate Contract I have signed with my contract agency.

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Contractor Signature/date

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Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Transformations Representative Signature/date