

SECURITY AUDIT INVOICE

Healthcare Cybersecurity Solutions LLC
123 Secure Way, Suite 500
Tech City, ST 12345

Invoice #: [0000]
Date: [Date]
Due Date: [Date]

Client (Covered Entity):

[Organization Name]
[Contact Person]
[Address Line 1]
[Address Line 2]

Audit Period:
[Start Date] to [End Date]
Project Code: [Code]

SERVICE DESCRIPTION	HOURS/UNITS	RATE	TOTAL
HIPAA Security Rule Risk Assessment	[0.00]	[\$[0.00]]	[\$[0.00]]
PHI Vulnerability Scanning & Penetration Testing	[0.00]	[\$[0.00]]	[\$[0.00]]
Administrative Safeguards Policy Review	[0.00]	[\$[0.00]]	[\$[0.00]]
Technical Controls Audit (Encryption & Access)	[0.00]	[\$[0.00]]	[\$[0.00]]

Subtotal: \$[0.00]

Tax/VAT (0%): \$[0.00]

Total Amount Due: \$[0.00]

Payment Instructions:

Please include Invoice Number on all transfers.

Bank Name: [Bank Name] | Account: [Number] | Routing: [Number]

This invoice covers professional services related to healthcare data security and HIPAA compliance auditing. All data handled during this audit is protected under the signed Business Associate Agreement (BAA).