621 East Center Avenue
Mooresville, NC 28115
704-799-7925
844-315-2237 Fax
www.allgenerationsaudiology.com

LIABILITY WAIVER AGREEMENT

This LIABILITY WAIVER AGREEMENT (this "Waiver") is entered into by and between _____ ("Patient") and All Generations Audiology, PLLC, a North Carolina professional limited liability company ("Provider"), and shall be effective _____ (the "Effective Date") or such other mandatory compliance date as may be set for the Privacy Rule enacted pursuant the Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations ("HIPAA"), including 45 C.F.R. Parts 160 and 164 ("Privacy Rule"). All terms used in this Waiver and not defined herein which are defined under HIPAA shall have the meanings set forth in the applicable definition under HIPAA.

1. Scope. As of the Effective Date, this Waiver applies to all present and future interactions between Patient and Provider, pursuant to which Provider receives from or receives or creates on behalf of, Patient, protected health information. As of the Effective Date, this Waiver, in addition to standing on its own, automatically extends to and amends all Applicable Agreements (defined herein) in effect on the Effective Date. Applicable Agreements shall mean any and all agreements between Patient and Provider.

2. Use and Disclosure of Protected Health Information. Provider may not use or disclose Protected Health Information (as defined in the Privacy Rule) ("PHI") or Electronic Protected Health Information ("ePHI"), received from, or received or created on behalf of, Patient, except as follows:
   (a) Provider is permitted to use or disclose PHI and ePHI as permitted or required by this Agreement or as required by law.
   (b) Provider is permitted to use or disclose PHI and ePHI to perform functions, activities and services for, or on behalf of, Patient as required for therapeutic purposes, including both in-person services, and services provided remotely or through electronic means.
   (c) Provider is permitted to use PHI and ePHI for the proper management and administration of the Provider or to carry out the legal responsibilities of the Provider.
   (d) Provider is permitted to disclose PHI and ePHI for the proper management and administration of the Provider, provided that (i) such disclosure is required by law or (ii) Provider obtains reasonable assurance from the person or entity to whom the PHI and ePHI will be disclosed that it will remain confidential and be used or further disclosed only for the specific purpose for which Provider disclosed it to the person or organization or as required by law, and the person or entity will notify Provider of any instance of which the person or organization becomes aware in which the confidentiality of such PHI and ePHI was breached.
   (e) Provider is permitted, upon Patient's request, to direct their ePHI to a third-party app for the sake of convenience of Patient and Provider shall not be liable or responsible or any unauthorized access to Patient's ePHI while in transmission to the app. By signing below, Patient acknowledges they understand the risk associated with requesting Provider to transmit Patient's ePHI to a third-party app. Further, Patient acknowledges that Provider and the third-party app developer and host are not affiliates or associated parties and that the app was not developed by, provided by or presented on behalf of Provider. Once Provider transmits Patient's ePHI, Provider is no longer in control of the ePHI and bears to responsibility for or control over the subsequent use or disclosure of the information received by the app. If such an app experiences a breach, Provider shall have no responsibility or liability. See 45 C.F.R. 164.524(a)(1)(c)(2)(ii) and (c)(3)(ii).

3. Safeguards. Provider agrees to use appropriate safeguards to prevent use or disclosure of PHI and ePHI received other than as permitted or required by this Waiver.

4. Reporting of Disclosures of Protected Health Information. Provider shall promptly report to Patient any use or disclosure of PHI and ePHI of which it becomes aware that is other than as provided for in an Applicable Agreement or under this Waiver.

[1]Subject to credit approval
[2]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your hearing aid(s).

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5. Agreement by Third Parties. Provider shall ensure, to the extent required by law, that any of its agents, including, but not limited to, manufacturers of medical devices, to whom it provides PHI and ePHI received from, or created or received by Provider on behalf of Patient, agree to substantially the same restrictions and conditions that apply to Provider under this Waiver with respect to such PHI and ePHI.

6. Access to Protected Health Information. Provider shall provide access, at the request of Patient, to PHI and ePHI in a designated record set (as defined in the Privacy Rule), to Patient, or as directed by Patient, to an individual in order to meet the requirements of 45 C.F.R. § 164.524.

7. No Third-Party Beneficiaries. Nothing expressed or implied in this Waiver is intended to confer, nor shall anything confer, upon any persons other than Patient and Provider, any rights, remedies, obligations or liabilities whatsoever.

8. Governing Law and Venue. This Waiver is governed by HIPAA laws and rules and the laws of the State of North Carolina. Patient and Provider agree that North Carolina is the proper venue for all matters under this Waiver and any Applicable Agreements.

BY SIGNING BELOW, I _____, AGREE TO THE TERMS OF THIS WAIVER AND RELEASE ALL GENERATIONS AUDIOLOGY, PLLC FROM LIABILITY STEMMING FROM ANY DISCLOSURES OF PHI or ePHI BEYOND THEIR CONTROL. I UNDERSTAND THAT, IN THE COURSE OF TREATMENT USING ELECTORNICALLY CONTROLLED MEDICAL DEVICES; MY PERSONAL INFORMATION MAY BE TRANSMITTED TO CERTAIN THIRD PARTIES. I UNDERSTAND THAT ALL GENERATIONS AUDIOLOGY, PLLC WILL TAKE REASONABLE STEPS TO ENSURE THE SAFETY OF MY INFORMATION AND RELEASE THEM FROM ANY LIABILITY FOR DISCLOSURES OF MY PHI and ePHI THAT MAY ARISE FROM THE USE OF SUCH MEDICAL DEVICES AS REQUIRE THE TRANSMISSION OF MY INFORMATION TO THIRD PARTIES.

Signature: _____ Date: _____

Relationship if not signed by patient (i.e. guardian, POA, etc.) _____

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