Authorization to Use and Disclose Health Information for Educational Purposes

We are asking you to let us use and disclose information about your medical condition and treatment for educational purposes.

You recently received treatment at the Sargent Choice Nutrition Center for **Name of Condition** . **Faculty Member Name** and possibly other BU faculty and instructors would like to use information about your diagnosis, treatment and follow-up in teaching students at Boston University. We will not use your name.

THE HEALTH INFORMATION WE WILL USE

We may use your information about your condition, health history, treatment, medications, response to treatment and other information pertinent to your condition and:

- ☐ Photos taken during your treatment
- ☐ Images (x rays, MRIs and similar)
- ☐ Video recordings
- ☐ Audio recordings
- ☐ None

PRIVACY OF YOUR HEALTH INFORMATION

Federal and state law require the Sargent Choice Nutrition Center staff, and health professionals to keep health information confidential, and we are careful to do so. Your signing this Authorization will permit us to share the information described above with students who are not yet health care providers and who are not required by law to follow the same confidentiality laws. However, the students have been trained to understand HIPAA and respect patient privacy.

LETTING US USE AND SHARE YOUR INFORMATION IS VOLUNTARY

Your participation is completely up to you. You will not receive any payment for allowing us to use your information. You do not have to agree to let us use or share your medical information. Your decision (either yes or no) will not affect your being able to get health care at the Sargent Choice Nutrition Center or payment for your health care. It will not affect your enrollment in any health plan or benefits you can get. Your permission will last until you notify us in writing that you wish to take it back.

YOU HAVE THE RIGHT TO TAKE BACK YOUR AUTHORIZATION

Write to: Boston University HIPAA Privacy Officer
Boston University
1 Silber Way, Room 909
Boston, MA 02215
hipaa@bu.edu

If you take back your authorization, it will not affect any actions we took before we received your letter.

SIGNATURE

If you sign this form, you are agreeing to let the Sargent Choice Nutrition Center and other BU faculty and instructors to use and/or disclose your health information as described above.

Printed Name

Relationship (if not patient)

Signature

Date