Authorization to Use and Disclose Health Information for Educational Purposes

PURPOSE OF DISCLOSURE

Educational purposes: teaching students, health professionals, fitness instructors, patients and others with an interest in your condition.

THE HEALTH INFORMATION WE MAY USE

We may use your information about your condition, health history, treatment, medications, response to treatment and other information pertinent to your condition. This may include using photos taken during your treatment, images such as xrays or MRIs, video recordings and audio recordings, in addition to information. We will not use your name.

DISCLOSURE WILL BE MADE TO:

Boston University faculty, instructors and staff.

PRIVACY OF YOUR HEALTH INFORMATION

Federal and state law require the BU Rehabilitation Services 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 and others who are not health care providers and are not required by law to follow the same confidentiality laws.

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 BU Rehabilitation Services 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 BU Rehabilitation Services use and/or disclose your health information as described above.

Printed Name

Relationship (if not patient)

Signature

Date