Authorization to Use and Disclose Health Information In A Publication

REQUEST TO USE AND DISCLOSE YOUR HEALTH INFORMATION

You have received dental treatment services at a GSDM Dental Health Treatment Center. ____________________, a ______________ with GSDM (the "Author") would like your permission to use your dental information and information about the dental services you received at the GSDM Dental Treatment Centers in a publication in the following journal: ______________________________, a journal that is is published in print and online. The Author will not use your name in the publication. But if your face can be seen in published images, or if you have shared information about your dental treatment, it is possible that a person could recognize you from the publication. The people who publish the journal will know your name because they require us to give them a copy of this form to be sure you have given permission.

THE HEALTH INFORMATION TO BE DISCLOSED AND USED

The Author may use information about your condition, diagnosis, health history, treatment, response to treatment and similar information. The Author may also use images taken during your treatment including photos, X-rays, and CBCT 3D imaging.

PRIVACY OF YOUR HEALTH INFORMATION

Federal and state law (including HIPAA) require the GSDM Dental Treatment Centers' dental professionals and staff to keep your health information confidential, and they are careful to do so. Your signing this Authorization will permit the GSDM Dental Treatment Center to share your health information with the Author to use in an article to be published in the Journal. Once your dental information is disclosed for this purpose, the disclosed information will no longer be protected by the same laws and may be subject to re-disclosure.

LETTING US USE AND DISCLOSE YOUR INFORMATION IS VOLUNTARY

Your agreement to allow the Author to use your health information for educational purposes is completely up to you; you do not need to agree. You will not receive any payment for allowing the Author to use your information. Your decision (either yes or no) will not affect your health care at the GSDM Dental Treatment Centers 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 revoke it.

YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION

If you sign this Authorization and later change your mind, you may revoke it by writing to: Henry M. Goldman School of Dental Medicine, Compliance & Quality Management, Office of the Dean, 635 Albany Street, Boston, MA 02118. Or you may email gsdmcomp@bu.edu. If you take back your authorization, it will not affect any actions taken before we received your letter, including publication.

SIGNATURE:

If you sign this Authorization, you are agreeing to allow the person named above to use and disclose your health information in a publication, as described above.

We appreciate your contribution to dental education!

Signature of individual or Legally Authorized Representative

Date

If Legally Authorized Representative, please specify relation to patient