Authorization to Use and Disclose Health Information for Educational and Academic purposes

OUR REQUEST

The GSDM Dental Health Treatment Center where you receive (or will receive) dental treatment services is an integral part of the Boston University Henry M. Goldman School of Dental Medicine (the "School"). The School would like your permission to use your dental information and information about the dental services you received at the GSDM Dental Treatment Centers in the education of its students at and for other academic purposes such as presentations at professional conferences. We will not use your name.

THE HEALTH INFORMATION WE MAY USE

The School may use your information about your condition, diagnosis, health history, treatment, medications, response to treatment and other information pertinent to your condition. The School 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 Treatment Center to share your health information with the School to use in the educational setting. Once your dental information is disclosed to the School for educational and other academic purposes, it will no longer be protected by the same laws and may be subject to re-disclosure. However, the School's faculty, instructors, staff and students are required to use the minimum information necessary for educational and academic purposes, and to protect the security and confidentiality of your health information.

LETTING US USE AND DISCLOSURE YOUR INOFRMATION IS VOLUNTARY

Your agreement to allow the School 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 School 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 we took before we received your letter.

SIGNATURE

If you sign this Authorization, you are agreeing to allow the GSDM Dental Treatment Centers to disclose your health information to the Goldman School of Dental Medicine for educational and academic purposes, 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