Authorization to Use and Share Health Information for BU Promotional Purposes

You have received health care services at one of the following BU Healthcare Providers:

GSDM Dental Health Clinics
Dental Health Center at 930 Commonwealth
The Danielsen Institute
BU Physical Therapy
BU Neuro Rehab
Sargent Choice Nutrition

BU and your Healthcare Provider would like to use your health information in promotional materialsabout BU and/or about your Healthcare Provider. We are asking your permission to use the following:

- ☐ Photograph or other image
- ☐ Video recording
- ☐ Audio recording
- ☐ Information about your diagnosis, treatment and progress

In this form, we refer to all of the above as "Your Health Information." If you authorize us to use Your Health Information, we may edit it, translate it, or use only part of it, and we may not use it at all. These promotional materials may be distributed publicly in a variety of ways, such as:

- ☐ We may post Your Health Information (including videos, audio recordings, photographs, and other images of you during your treatment) on our Boston University website (www.bu.edu), other internet sites, and on social media
- ☐ We may use Your Health Information in a podcast, webcast, broadcast or other form of electronic distribution
- ☐ We may include Your Health Information in printed materials

We will not use your full name, but people who know you may recognize you.

Federal and state law require your Healthcare Provider and its staff, health professionals and other workforce members to keep Your Health Information confidential. That is why we need your authorization to share Your Health Information. Once we disclose Your Health Information, it will be public and, in that context, will not be subject to the same privacy protections as within your Healthcare Provider.

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 and disclose Your Health Information. You do not have to agree to let us use or disclose Your Health Information. Your decision (either yes or no) will not affect your being able to get health care at your Healthcare Provider, or insurance coverage for your health care. It will not affect your enrollment in any health plan or any benefits you may access. This Authorization will expire 1 year after the date you sign it, if you do not first revoke it. After 1 year, we will not use Your Health Information in any new promotional materials but existing promotional materials may still be publicly accessible.

RELEASE

Your signature below confirms you agree to waive any right to inspect or approve of the promotional materials.

Your signature below also confirms you release BU, your Healthcare Provider, and all of their employees and agents from all legal claims or damages relating to the use of your Health Information as authorized herein.

YOU MAY REVOKE THIS AUTHORIZATION

If you wish to take back this authorization, you need to 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 actions we took before we received your letter or any publications already printed, posted or distributed.

SIGNATURE

If you sign this form, you are agreeing to allow your BU Healthcare Provider and Boston University use and/or disclose your health information as described above.

Printed Name

Relationship (if not patient)

Signature

Date