

## Authorization to Use and Share Health Information

**We are asking you to let us use and share *{your photograph and}* information about your medical condition and treatment for a medical/dental journal case report.**

* You recently received treatment at the Henry M. Goldman School of Dental Medicine Patient Treatment Centers or the BU Dental Health Center (together the “GSDM Clinical Centers”) for *{name of condition}*. *{Author/provider}* and the other providers involved in your care would like to submit *{your photograph and}* information about your diagnosis, treatment and follow-up to a medical/dental journal: *{name of journal}*. The purpose is to inform and teach other health care providers. The journal is published in print and on the internet.

**What is in the case report *{and photograph}*?**

* *{The picture will show your condition. }*The case report will describe your condition and discuss your health and treatment, including prior health history, present complaints, and laboratory and diagnosis facts. You will receive no payment for being in the case report.
* We will not use your name on our case report {*or on the pictures that we put in the case report*}. But, *{if your face can be seen or}* if you have shared your medical story, people who know you may be able to tell who you are. The people who publish the journal will know your name because they require us to give them a copy of this form. They want to be sure that a person in a journal article has given permission. However, they won’t tell anyone else your name.

**Privacy of your health information.**

* Federal and state law require the GSDM Clinical Centers’ work force, staff, and health professionals to keep health information confidential. The federal Privacy Rule may not protect health information that you permit us to share with people outside of the GSDM Clinical Centers.

**Letting us use and share your information is voluntary.**

* Your participation is completely up to you. You do not have to agree to let us use or share your *{pictures or}* medical information. Your decision (either yes or no) will not affect your being able to get health care at the GSDM Clinical 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 the authors send the final version of the article to the journal.

**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.

**If you sign this form, you are agreeing to let GSDM and your health care providers use or give out your health information as described above**.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship (if not patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**