New York College of Health Professions

HIPAA Authorization for Use or Disclosure of Information For Educational and Related Purposes

I, _____, hereby authorize New York College of Health Professions to use or disclose the following protected health information (Check one or more of the following):

- ❑ Video Recordings
- ❑ Audio Recordings
- ❑ Medical Record Information
- ❑ Photographs
- ❑ X-Rays and other diagnostic test results/films

The information checked off above may be used by NYCHP students and/or faculty members.

This protected health information is being used or disclosed for the following educational purposes (check one or more of the following):

- ❑ Current and future classroom activities within NYCHP
- ❑ Current and future clinical and qualifying exams within NYCHP
- ❑ Publications within educational journals or books
- ❑ Presentations at educational/professional conferences
- ❑ Educational Activities supporting obtainment by students of necessary supervision credit

This authorization shall be in force and effect until the end of the educational purpose at which time this authorization to use or disclose this protected health information expires.

I understand that, as set forth in NYCHP's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

New York College of Health Professions
6851 Jericho Turnpike, Suite 210
Syosset, NY 11791
ATTN: IRB Director

I understand that a revocation is not effective to the extent NYCHP has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal or state law.

I understand that NYCHP will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to

- Inspect or copy my protected health information to be used or disclosed
- Refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (if applicable)