

Notice of Privacy Practices Acknowledgment Form

By signing my name below, I acknowledge receiving a copy of the St. John's University Speech and Hearing Center's Notice of Privacy Practices

Date _____

Name _____

**AUTHORIZATION
for Disclosure and Use of
PROTECTED HEALTH INFORMATION**

Name and address of individual:

Description of the protected health information which is to be disclosed:

Information is to be disclosed BY:

ST. JOHN'S UNIVERSITY SPEECH AND HEARING CENTER

Information is to be disclosed TO:

Purpose(s) of disclosure or use:

Date or event on which this authorization expires:

Comments (optional):

Acknowledgements:

This Authorization may be revoked in writing at any time, except to the extent that the entity disclosing the information has already relied upon it. Signing this Authorization is not a condition for treatment, payment, enrollment, or eligibility for benefits. I understand that if this Authorization allows my protected health information to be disclosed to a recipient that is not a health care provider or a health plan, the information disclosed may no longer be protected under the HIPAA Privacy Rule.

SIGNATURE

Date signed:

If this authorization is signed by a personal representative of the individual, the representative's authority to act on behalf of the individual is:

**ST. JOHN'S UNIVERSITY
SPEECH AND HEARING CENTER**

**AUTHORIZATION
for Disclosure and Use of
PROTECTED HEALTH INFORMATION
FOR RESEARCH PURPOSES**

Patient name: _____

I authorize the Speech and Hearing Center to disclose my protected health information for research purposes to researchers who are under the jurisdiction of the St. John's University Institutional Review Board. Such disclosures may be made only to the extent necessary for research purposes.

I understand that researchers at St. John's University who engage in approved research activities will take precautions to safeguard the confidentiality of my protected health information. I also understand that if this authorization allows my protected health information to be disclosed to a recipient that is not a health care provider or a health plan, the information may no longer be protected under the HIPAA Privacy Rule.

I understand that I am not required to sign this authorization in order to receive treatment at the Speech and Hearing Center.

I understand that I may revoke this authorization in writing at any time. However, disclosures that the Speech and Hearing Center has already made before receiving my revocation will not be taken back.

Unless I specify otherwise below, this authorization has no expiration date.

Comments (optional): _____

SIGNATURE

Date signed:

If this authorization is signed by a personal representative of the individual, the representative's authority to act on behalf of the individual is:
