Office of Practice & Community Health Center

East Tennessee State University
College of Nursing
P.O. Box 70403
Johnson City, TN 37614
(423) 439-4077

Hancock County School-Based Health Centers
P.O. Box 723
Sneedville, TN 37869
Middle/HS (423) 733-2819
Elementary (423) 733-2121

Johnson City Community Health Center
2151 Century Lane
Johnson City, TN 37604
(423) 926-2500

HIPAA AUTHORIZATION

PATIENT NAME _____ DOB:_____

I authorize East Tennessee State University (ETSU) College of Nursing (CON) Community Health Centers (CHC) to discuss and \or release my medical information including labs and test results, diagnosis, and treatment discussed to the following persons:

1.	**Name**	**Relationship to patient**	**Phone Number**
2.	**Name**	**Relationship to patient**	**Phone Number**
3.	**Name**	**Relationship to patient**	**Phone Number**

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES
&
NOTICE OF PRIVACY PRACTICES

I acknowledge that the East Tennessee State University (ETSU) College of Nursing (CON) Community Health Center (CHC) has provided me with a written copy of Patient Rights and Responsibilities. This information clearly defines my rights and responsibilities as a patient receiving services by a CHC associated provider.

I have also been given the opportunity to review the East Tennessee State University (ETSU) Notice of Privacy Practices and understand that the Notice indicates how my protected health information may be used and disclosed and how I gain access to this information. I have also been given the opportunity to receive a copy of the ETSU Notice of Privacy Practices for further review

AUTHORIZATION AND RELEASE

I understand that the ETSU CON CHC serves as a training center for students majoring in, but not limited to, Nursing, Audiology, Dental Hygiene, Nutrition, Radiology, and Speech-Language Pathology at ETSU. For this reason, I authorize the use of student observation, video recording, audio recording, pictures, client data, and discussion for professional research or educational purposes. I understand that no names or identifying information will be used in any of these procedures.

I understand that the evaluation and treatment procedures used by the Speech Language Pathologists\Audiologists are non-medical in nature. These procedures meet professional and ethical standards of the American Speech-Language-Hearing Association, and they offer no physical or psychological risk. Although the treatment procedures are expected to be beneficial, I understand that no guarantee of success can be expressed or implied.

By signing below, I agree to the above-mentioned statements.

Patient Printed Name	**Patient/Guardian Signature**	**Date**
CHC Staff Signature	**Date**	