

Barrington Rehabilitation Authorization to Release Information

(Photocopy / Facsimile may be used as an original)

NAME	<i>Last</i>	<i>First</i>	<i>MI</i>
DATE OF BIRTH:		SOCIAL SECURITY #:	
AKA			

UNDERSTANDINGS:

1. I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
2. I understand BARRINGTON REHABILITATION will not deny treatment, payment, enrollment or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of medical records or other medical information. I may inspect or copy any information used or disclosed under this authorization.
3. I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to the Privacy Officer. The revocation will be effective upon receipt by BARRINGTON REHABILITATION, except to the extent that action has already taken place.
4. I further understand that, this authorization will expire as follows:
 - Sixty (60) days from the date that I have signed this form. After the expiration date, this authorization will no longer be effective, and no further information will be furnished without additional authorization.
5. I understand that there may be a charge to cover actual costs incurred in preparing and delivering the information requested in this authorization, in accordance with State statutes and our policies. The fee is currently \$10.00-20.00 for complete records. There is **no charge** for medical records if copies are sent to facilities for ongoing care or follow up treatment.

REQUEST: Submit this completed form to the Privacy Officer located at 27401 W. IL ROUTE 22, BARRINGTON, IL, PH: 847-381-8812/FX: 847-381-6311

I hereby authorize BARRINGTON REHABILITATION to release information from my medical record as indicated below to:

Name: _____

Address: _____
Street City State Zip

Phone: (____) _____ Fax: (____) _____

<p>DATES AND TYPES OF INFORMATION TO DISCLOSE:</p> <p><input type="checkbox"/> From Date: _____</p> <p><input type="checkbox"/> To Date: _____</p> <p>Specific Information Requested:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>PURPOSE OF THE DISCLOSURE:</p> <p><input type="checkbox"/> Change in Insurance or Physician</p> <p><input type="checkbox"/> Continuation of Care</p> <p><input type="checkbox"/> Referral</p> <p><input type="checkbox"/> Other _____</p>
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SIGNATURE: _____	DATE: _____
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WITNESS: _____	DATE: _____
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<p>PRINTED NAME: _____</p> <p>ADDRESS: _____</p> <p>CITY: _____ STATE: _____</p>	<p>RELATIONSHIP: <input type="checkbox"/> Client/Patient <input type="checkbox"/> Parent <input type="checkbox"/> Guardian</p> <p><input type="checkbox"/> Representative <input type="checkbox"/> Conservator <input type="checkbox"/> Other _____</p> <p>ZIP: _____ PHONE: _____</p>
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