Barrington Rehabilitation
Patient Release and Consent

NAME	***Last***	***First***	***MI***
DATE OF BIRTH:		**SOCIAL SECURITY #:**	
AKA			

UNDERSTANDINGS:

1. I understand BARRINGTON REHABILITATION cannot release / disclose my protected medical records and information without my written permission, including my appointments and case information.
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 **one year** 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.

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 the individual below permission to act on my behalf with no limitations. I understand that they may contact any therapist or member of the staff at BARRINGTON REHABILITATION to schedule appointments, discuss my healthcare and access my medical records with **NO RESTRICTIONS**.

_____I hereby authorize the individual below permission to speak with any therapist or front desk staff at BARRINGTON REHABILITATION **TO DISCUSS MY CARE AND/OR SCHEDULE ANY APPOINTMENTS. I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS**.

_____I hereby authorize the individual below permission to **ONLY SCHEDULE MY APPOINTMENT. I DO NOT ALLOW THE THERAPIST TO DISCUSS MY CASE OR GRANT ACCESS TO MY MEDICAL RECORDS**.

_____**I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS OR APPOINTMENTS TO THE PERSON(S) LISTED BELOW.**

I GRANT ACCESS TO MY MEDICAL INFORMATION TO THE FOLLOWING PERSON(S):

Name(s):_____

Address: _____
Street City State Zip

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

PRINTED NAME OF PATIENT: **DATE:**

SIGNATURE: **DATE:**

BARRINGTON REHABILITATION WITNESS: **DATE:**