

**BARRINGTON REHABILITATION
REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PHI**

(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:

I understand that **BARRINGTON REHABILITATION** has an obligation to provide an accounting of disclosures of PHI that the clinic has made in the six years prior to the date on which the accounting is requested.

I also understand that there may be a time when specific disclosure cannot be reported. This would occur when a health oversight agency or law enforcement official has notified **BARRINGTON REHABILITATION** that an accounting of disclosures to the agency or official about the individual must be suspended. The health oversight agency or law enforcement official must provide a statement **BARRINGTON REHABILITATION** that such a disclosure would be reasonably likely to impeded the activities of the agency or the official and specify a time period for the suspension **BARRINGTON REHABILITATION** shall limit the temporary suspension to no longer than thirty (30) days from the date of the statement unless the health care oversight agency or law enforcement official has stated otherwise.

I understand that **BARRINGTON REHABILITATION** does not have to tell me about the following types of disclosures and that these disclosures will not be included in the accounting provided to me:

1. Disclosure for purposes of treatment, payment and health care operations or as part of a limited data set.
2. Disclosures to me or disclosures authorized by me.
3. If **BARRINGTON REHABILITATION** uses a facility directory, disclosures for use in a facility directory.
4. Disclosures to persons involved in my care.
5. For notification purposes (to notify a family member, personal representative or other person of the individual's location, general condition or death).
6. For national security or intelligence purposes.
7. To correctional institutions or law enforcement officials.
8. Disclosures made prior to April 14, 2003.
9. Disclosures incident to a use or disclosure otherwise permitted or required by federal law.
10. Disclosures of de-identified information.

I understand that **BARRINGTON REHABILITATION** must give me the accounting of disclosures within 60 days, or tell me that it needs an extra 30 days (or less) to prepare it.

I am entitled to one free accounting of disclosures in any 12 month period. Additional accountings within that 12 month period will cost \$ 25.00.

REQUEST: Submit this completed form to the Privacy Officer located at 27401 W. IL Route 22, Suite 107, Barrington, IL, Ph: 847)381-8812; Fax: 847) 381-6311

I request an accounting of disclosures of my protected health information made by **BARRINGTON REHABILITATION** to include disclosures made between the following dates:

Start date: _____ End date: _____

I request the information be provided to me in Paper Format Electronic Format (encrypted CD or DVD).

Please send my accounting to the address below. I want to pick up the accounting. Please call me at the phone number below when it is ready.

If you believe your privacy rights have been violated, you may file a complaint with the or with the Secretary of the Department of Health and Human Services.

To file a complaint with **BARRINGTON REHABILITATION** contact the Chief Compliance Officer at **(847) 381-8812**.

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

SIGNATURE:

TODAY'S DATE:

PRINTED NAME:

RELATIONSHIP: Client/Patient Parent Guardian

Representative Conservator Other _____

ADDRESS:

CITY: _____ **STATE:** _____

ZIP: _____ **PHONE:** _____