BARRINGTON REHABILITATION
REQUEST FOR RESTRICTION OF USE OR DISCLOSURE OF PHI
(Photocopy / Facsimile may be used as an original)

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

UNDERSTANDINGS:

I understand that **BARRINGTON REHABILITATION** may use or disclose my protected health information (PHI) for the purposes of treatment, payment, and health care operations. With my permission and in certain limited circumstances, the **BARRINGTON REHABILITATION** may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend. I also understand that **BARRINGTON REHABILITATION** is not required to agree to the restriction request and that the restriction will not be effective unless the HIPAA Privacy Officer agrees to it in writing below.

Even if **BARRINGTON REHABILITATION** agrees to the restriction, it may share the information anyway in the following circumstances:

1. During a medical emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed during an emergency, **BARRINGTON REHABILITATION** will request that the recipient will not use or disclose it for any other purposes.
2. If **BARRINGTON REHABILITATION** uses a facility directory in their directory.
3. For certain public health activities such as to prevent or control disease, injury or disability.
4. For reporting abuse, neglect, domestic violence or other crimes.
5. For health agency oversight activities such as auditing, investigations, inspections and expenditures.
6. For law enforcement investigations regarding the investigation of criminal activity.
6 For judicial or administrative proceedings in response to a subpoena, court order or other similar process.
7. For identifying decedents to coroner and medical examiners or determining a cause of death.
8. For organ procurement.
9. For certain research activities.
10. For workers' compensation programs.
11. For uses or disclosures otherwise required by law.

If a special restriction is agreed to, it may be terminated if:

1. I request, or agree to, the termination in writing.
2. I orally agree to the termination and the oral agreement is documented.
3. **BARRINGTON REHABILITATION** informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created by **BARRINGTON REHABILITATION** or received by **BARRINGTON REHABILITATION** after I am notified of the termination.

REQUEST: Submit this completed form to the Privacy Officer located at 27401 W. IL Route 22, Barrington, IL 60010, Phone (847) 381-8812, Fax (847) 381-6311

I hereby request that **BARRINGTON REHABILITATION** honor the following restrictions regarding the use and disclosure of the PHI of the individual listed above.

I want to limit the following information:

_____

_____

I want to limit:

❒ **BARRINGTON REHABILITATION's** use of this information. ❒ **BARRINGTON REHABILITATION's** disclosure of this information. ❒ Both use and disclosure of this information.

I want the limits to apply to the following person/entity (for example, a spouse):

_____

A copy of the Notice of Privacy Practices is also available at all BARRINGTON REHABILITATION facilities, or you may contact the BARRINGTON REHABILITATION Privacy Officer at (847) 381-8812.

SIGNATURE: **TODAY'S DATE:**

PRINTED NAME: _____

RELATIONSHIP: ❒ Client/Patient ❒ Parent ❒ Guardian ❒ Representative ❒ Conservator ❒ Other _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **PHONE:** _____

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FOR OFFICE USE ONLY **REVIEW OF REQUEST FOR RESTRICTION**		
❒ **Restriction Accepted**	❒ **Restriction Accepted In Part**	❒ **Restriction NOT Accepted**

Reason NOT Accepted or Partially Accepted:

_____

_____

HIPAA Privacy Officer: _____ **Date:** _____

Date Restriction Begins: _____

REQUEST FOR TERMINATION OF RESTRICTIONS

The above restriction was requested to be terminated by_____
(entity or individual)

The Request for Termination of Restrictions was made ❒ orally ❒ in writing.

The request was initiated on _____ (Date)

The restriction will be terminated effective: _____ (Date)

❒ If box is checked, the termination applies **ONLY to** PHI created or received on or after the effective date of the termination.