ABA & VERBAL BEHAVIOR GROUP

Request for Restrictions Of Protected Health Care Information

Please complete the following information:

Client Full Name	Date of Birth
Parent/Legal Guardian Full Name	Telephone number (s) Email Address

Client Rights: ABA & Verbal Behavior Group must permit clients to request restrictions of their protected health information (PHI). Clients may request uses and disclosures of PHI for treatment, payment and healthcare operations; disclosures to a family member, close person friend or any other person identified by the client; and disclosures of PHI to notify or assist in the notification of a family member, personal representative or another person responsible for the care of the client of the client's location, general condition or death. All requested must be submitted in writing.

ABA&VBG Responsibilities: ABA&VBG is not required to grant most restrictions and is precluded from granting restrictions that would violate the law and may use and disclose the restricted information in appropriate emergency situations, If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement.

To exercise your right to request a restriction on our use and disclosure of your protected health information, please specify the information you want to be handled in a restricted fashion, and the restrictions you want us to apply:

Print Name of Client	Print Name of Parent/Legal Guardian
Signature of Parent/Legal Guardian	Date

THIS SECTION TO BE COMPLETED BY ABA&VERBAL BEHAVIOR GROUP PERSONNEL ONLY

The above request for restriction of PHI is Granted _____ Denied _____
Reason(s) for Denial, if applicable:

Signature of ABAVBG Privacy Officer	Date
Email	Phone number

Original to be kept in permanent client file.