IMPERIAL COUNTY
BEHAVIORAL HEALTH SERVICES
202 N. EIGHTH STREET
EL CENTRO, CA 92243

REQUEST FOR SPECIAL RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this form gives you the opportunity to request Imperial County Behavioral Health Services to restrict its use or disclosure of your protected health information.

IDENTIFYING INFORMATION

Date:	Name:	DOB:

Address:	City/Zip:	Phone:

- I understand that Imperial County Behavioral Health Services (ICBHS) may use or disclose my protected health information ("PHI") for the purposes of treatment, payment and health care operations. I hereby request a restriction on ICBHS' use or disclose of protected health information.
- The information I want limited is:

_____

_____

- I want to limit:
  - ☐ ICBHS' use of this information.
  - ☐ ICBHS' disclosure of this information.
  - ☐ Both the use and the disclosure of this information.
- I want the limits to apply to the following persons/entity(ies):

_____

ACKNOWLEDGMENTS

I understand that ICBHS does not have to agree to my request. Even if ICBHS agrees to the restriction, it may share the information anyway in the following circumstances:

- During an emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed during an emergency, ICBHS will tell the recipient not to use or disclose it for any other purposes.
- For reporting abuse, neglect, domestic violence or other crimes.
- For health agency oversight activities or law enforcement investigations.
- For judicial or administrative proceedings.
- For identifying decedents to coroner and medical examiners or determining a cause of death.
- For certain research activities.
- For uses or disclosures otherwise required by law.

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

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

SIGNATURE

_____ _____

Signature of Client/personal representative | If personal representative, give relationship

Original: Chart Canary: Client Pink: Privacy Officer

NOTICE OF RIGHTS AND OTHER INFORMATION

Your Rights When Requesting Restriction of Information:

- You have a right to request restrictions on the uses and disclosures of your information.
- You have a right to have an answer to your request within 60 days. If there are delays in getting you the answer, you will be told. The delay cannot be more than 30 days. You'll receive an answer in writing.
- Your request and the answer will be kept in your record.
- If ICBHS agrees to your request, the restricted information will not be used or disclosed.
- ICBHS may end its agreement to your restriction if you ask to agree to end the restriction. Your request and ICBHS' action will be in writing and placed in your record.
- Information in our record that was created or received while the restriction was in place will remain subject to the restriction.

For more information about your privacy rights, see the "Notice of Privacy Practices" available in all of our lobbies and buildings.

If you believe your privacy rights have been violated, you may file a complaint with ICBHS or with the Secretary of the Department of Health and Human Services. All privacy complaints must be submitted in writing. You will not be penalized for filing a complaint.

A privacy complaint may be directed to:

ICBHS Privacy Officer
202 N. Eighth Street
El Centro, CA 92243
Phone: (442) 265-1560
Fax: (442) 265-1583