SUMMACARE

REQUEST FOR
ACCOUNTING OF DISCLOSURES

I hereby request an accounting of disclosures made by SummaCare other than for treatment, payment, operations of SummaCare, or other permitted activities described in the Notice of Privacy Practices.

Period of time for which you wish to see the disclosures: ____/____/_____ - ____/___/_____
MM DD YYYY MM DD YYYY

Note that you can request a list of disclosures for any time period after April 14, 2003.

We are not required by law to include any of the following disclosures of your health information:

- Disclosures made in response to an authorization signed by you or your representative;
- Disclosures to carry out our own or other providers' or plans' treatment, payment and health care operations;
- Disclosures made to you or your personal representative;
- Disclosures made to persons involved in your care and/or payment or notification of next-of-kin or family members;
- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials about inmates or others in custody; or
- Disclosures that occurred prior to April 14, 2003.

If you request more than one accounting in any 12 month period, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or change your request at that time before any costs are incurred. We have 60 days to provide the information to you. If we are unable to provide you the information within 60 days, we will send you a notice of the reason for the delay and we will have an additional 30 days to respond.

Please print the following information:

Member name: _____ Date of birth: _____

Member ID: _____ Daytime Phone: _____

Address: _____

Alternative Phone: _____

Member Signature:_____ Date: _____

Legal Representative Signature*: _____ Date: _____

Relationship to Member: _____

***If you are a legal representative of the member, you must attach copies of your authorization as required by state law to represent the member – for example, healthcare power of attorney or guardianship papers.**

Please mail this form to SummaCare
Attention: Corporate Services
10 N Main Street
Akron, Ohio 44308

FOR SUMMACARE USE ONLY	
Person Reviewing: _____	**Date Reviewed:** _____
Disposition of request: _____	**Date Notice sent to Member:** _____
Date of Member's rescission of Restriction: _____	**Member has rescinded orally or in writing:** _____