



AUTHORIZATION FORM FOR USES AND DISCLOSURES OF MEMBER INFORMATION

(Member must complete all shaded statements)

I hereby authorize the use or disclosure of my protected health information as described below.

1. If you are the **representative of a member**, describe the scope of your authority to act on the member's behalf, and provide documentation of such authority (Examples include Power of Attorney or Letter of Guardianship):

2. **This authorization was prepared (Check as applicable):**

At the request of SummaCare for the following purpose:

Marketing, which includes: _____

If the authorization is to permit the use or disclosure of the member's information for marketing, indicate whether SummaCare will receive any remuneration or payment from a third party as a result of the marketing: **(to be completed by SummaCare)**

Yes

No

Research Study which includes: _____

At the request of the member

Other _____

3. **Describe fully the information that is the subject of this authorization and which will be used or disclosed as set forth below (Examples include Claims, appeals or "all information")**

4. **Complete the following:**

SummaCare may release my personal health information which is described above to the following person(s):

Provide a copy of this signed form to the member

The above named person(s) understands that they will be asked to provide identifying information when he or she calls SummaCare to discuss the member's PHI. (Examples include mother's date of birth, last four (4) digits of the social security number). Please provide such information below to be used to identify the named person's authority to receive such information.

5. I understand that if the person or entity that receives the above information is a not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. Further, if the information is disclosed by the member's named representative, SummaCare will not be liable.
6. As described in the Notice of Privacy Practices of SummaCare, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by SummaCare in reliance on this authorization, by sending a written revocation to **Customer Services, P.O. Box 3620, Akron, Ohio 44309.**
7. **This authorization will expire: (Check as applicable; must be completed and specific)**
 - End of research study (applicable only if the authorization is for a research study or for creation and maintenance of a research database or research repository)
 - End of Marketing Activities
 - When Coverage Ends.
 - Other [**You must enter a date or event**] _____.
8. I understand that I am not required to sign this authorization form and not signing this form will not affect payment of claims by SummaCare. However, if you do not sign this authorization form, SummaCare will not provide information to anyone, except to a covered entity under HIPAA for the purpose of treatment, payment or operations.

Member Name

Name of personal representative, if applicable

Member Number

Relationship of personal representative to member

Signature of member/date

Signature of member's representative/date

Signature of SummaCare representative/date

If signing as member's representative, you must provide documentation of your authority to act on member's behalf.

Provide a copy of this signed form to the member