



## REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION

I hereby request restriction(s) on the uses and disclosures of my personal health information.

I understand that SummaCare is not required to agree to my restriction request. I further understand that SummaCare reserves the right to terminate an agreed-to restriction with written notification if it believes that termination is appropriate. I also have the right to terminate, in writing, any restriction by sending a termination notice to SummaCare, attention Compliance Department.

Please give a full, specific description of the type of restrictions you are requesting regarding how and to whom your personal health information is used and disclosed. Restrictions may only be requested for those uses and disclosures that relate to your treatment, your payment or health care insurance, or the business operations of **SummaCare**.

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**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

<b>FOR SUMMACARE USE ONLY</b>	
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Date of Member's rescission of Restriction:	Member has rescinded orally or in writing: