Zing HEALTH™ Accounting of Disclosures Request

PLEASE COMPLETE THIS FORM TO GET ACCOUNTING OF DISCLOSURES

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.

Mail the signed form to:

Zing Health
225 W. Washington Street, Suite 450
Chicago, IL. 60606

If you need assistance completing the form, call the Customer Service number listed on your Member ID Card.

Section 1. Member Information			
Member Last Name:	Member First Name		Member Middle Name:
Date of Birth:	Member ID#:		
Street Address:			
City:	State:	Zip Code:	Phone Number:

I would like an accounting of how my protected health information was disclosed by Zing Health, as required by federal regulations. I understand that Zing Health does **NOT** have to tell me about the following types of disclosures:

1. Disclosures for purposes of treatment, payment and health care operations or as part of a limited data set.
2. Disclosures to me or disclosures authorized by me.
3. Disclosures to persons involved in my care.
4. For notification purposes (to notify a family member, personal representative or other person authorized by law of the individual's location, general condition or death).
5. For national security or intelligence purposes.
6. To correctional institutions or law enforcement officials.
7. Disclosures made prior to April 14, 2004.
8. Disclosures incident to a use or disclosure otherwise permitted or required by state or federal law.

I also understand that my right to an accounting of some or all disclosures may be suspended by the government under limited circumstances.

Record Type(s)

The list is provided free once in any 12-month period. Zing Health may charge a reasonable cost-based fee for any additional requests in the same 12-month period, the amount of which will be disclosed to you in advance. The list that you have requested will be provided to you within 60 calendar days unless Zing Health notifies you in writing that a 30 – day extension is needed.

I am asking for a listing of disclosures of my PHI for the following period of time [be specific]:

From: _____ To:_____

I am asking for a listing of disclosures of my PHI from the following kinds of records:

_____ Health plan enrollment and eligibility records.

_____ Claims records for your services and treatments.

_____ Records used by us to decide whether or not to approve an authorization request.

_____ Records that the health plan has mailed to you in the past.

____ I would like to pick up the list when it is ready. Please call me at the following telephone number when it is ready: _____.

____ Please mail the list to the address given above.

____ Please mail the list to this address:

_____

_____

_____

Signature

Requester's Signature: _____

Date: _____

THE FOLLOWING INFORMATION IS NEEDED IF THE REQUESTER IS A PERSONAL REPRESENTATIVE

IF THE PERSON SIGNING THE FORM IS NOT THE MEMBER WHO IS THE SUBJECT OF THE REQUESTED INFORMATION, WRITTEN EVIDENCE OF THE PERSON'S AUTHORITY TO RECEIVE THE REQUESTED INFORMATION MUST BE PROVIDED. THAT EVIDENCE MAY BE IN THE FORM OF A WRITTEN AUTHORIZATION FROM THE MEMBER OR A DESIGNATION FROM A COURT OF COMPETENT JURISDICTION

Print Name: _____ Date:_____

Relationship: _____

For Office Use Only

Date Received: _____ Sent to: _____ Title: _____

Date Processed: _____ Sent to: _____ Title: _____