MEDICAL MUTUAL®

Revocation of Authorization for the Use or Disclosure of Protected Health Information

Please revoke my previous authorization to provide my protected health information to the individual or entity named below.

Please note: Items marked with an asterisk (*) are required.

Member Information			
Last Name*	First Name*	MI	Birthdate
Group Number	Member ID Number*		

Explanation for Revocation*
Please explain your request and provide the **full name and contact information** of the authorized individual or entity whose access you are revoking. (Note: The revocation will not apply to information released prior to Medical Mutual's receipt of this revocation form.)

Signature*	
Member Signature	Date

If you are an authorized representative, please sign below and enclose supporting documentation as required by state law (such as power of attorney, estate documentation or guardianship papers).		
Signature of Authorized Representative	Relationship	Date

Please complete all sections above. Send the signed and completed form to:

Medical Mutual
P.O. Box 89499
Cleveland, OH 44101-6499

Medical Mutual will review your request and provide you with a written response.

For more information, see the Notice of Privacy Practices at MedMutual.com, or call the Customer Care number on your member identification card to request a copy.