MEDICAL MUTUAL®
CAROLINA CARE PLAN | CONSUMERS LIFE

Restriction on Use or Disclosure of Information

PRIVACY & CONFIDENTIALITY REQUEST FORM

(OPS)
P.O. Box 89499
Cleveland, OH 44101-6499

Please complete all sections of this form.

I am requesting that my personal health information receive special treatment. I am requesting additional restrictions on my health information when used for treatment, payment, or other day-to-day operations. I understand that Medical Mutual is not required to agree to this restriction.

Your General Information: * *Required Information*	
Last Name: *	First Name: * M.I.
Medical Mutual ID Number: *	Birth Date (MM/DD/YY):
Group Number: *	

Request Information:
To restrict use or disclosure of your personal health information when used for treatment, payment, or other day-to-day operations: Use the space below to describe your specific request. (*Medical Mutual is under no obligation to agree to your request.*)

Closing:	
Signature: *	Date: *

For more information, refer to the Medical Mutual Privacy Notice located at MedMutual.com, or to receive a copy, call the Customer Service telephone number on your identification card.

Send completed and signed form to:

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