MEDICAL MUTUAL®

Authorization for the Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act (HIPAA), Medical Mutual of Ohio and its subsidiaries (collectively, Medical Mutual) may not use or disclose your protected health information except as provided in our Notice of Privacy Practices. Your signature on this form indicates you are giving permission for Medical Mutual to provide your protected health information to the person or entity named below. 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.

Notice for MedMutual Advantage members: If you would like to designate a representative in connection with a claim, prior authorization, grievance, appeal, or any other Medical Mutual decision affecting your care or the services you receive, please complete the Appointment of Representative form at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf, and mail to: Medical Mutual, Attn: P.O. Box 89499, Cleveland, OH 44101-6499.

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

Member Information

Last Name*	First Name*	MI	Birthdate

Group Number	Member ID Number*

Information to be Disclosed*

I authorize Medical Mutual to disclose my protected health information to the following individual or entity:

Name	Relationship

Street Address	City	State	ZIP Code

The specific health information to be used or disclosed:

- ☐ Any and all protected health information Medical Mutual maintains, including but not limited to mental health, HIV or substance abuse records
- ☐ Claim payment information
- ☐ Health premium payment information
- ☐ Application/enrollment information
- ☐ Other:

Reason or purpose of requested disclosure to the individual or entity named above:

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Authorization*		
Unless this authorization is revoked, I understand this authorization will expire when Medical Mutual no longer maintains my protected health information. I also understand I may revoke this authorization at any time by providing Medical Mutual with written notice of revocation at the address listed below. If I do revoke this authorization, it will not have any effect on any information released before the revocation, including any action taken by the individual or entity that received the health information. Protected health information used or disclosed as instructed by this authorization may be further disclosed by the individual or entity receiving the health information and, therefore, no longer protected by the HIPAA privacy law. I understand I am under no obligation to sign this authorization. I further understand my ability to obtain insurance or eligibility for benefits will not depend in any way on whether I sign this authorization. I authorize the use or disclosure of my protected health information as indicated above by Medical Mutual to the above individual or entity.		
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