MEDICAL MUTUAL®

Authorized Contact Request Form

I authorize the person(s) named below to act as my personal representative regarding my protected health information, within the limits allowed by law and Medical Mutual policy.

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

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

Authorized Representative Information			
This individual will remain as authorized to act on your behalf until you notify Medical Mutual in writing of your intention to withdraw this authorization.			
Name*		Relationship*	
Street Address*	City*	State*	ZIP Code*
Primary Phone Number*	Secondary Phone Number	Email Address	

Signature*	
Member Signature	Date

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

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

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.