MEDICAL MUTUAL®

Authorized Contact Request Form

PRIVACY & CONFIDENTIALITY REQUEST FORM

(MEMB)
2060 East Ninth Street
Cleveland, OH 44115-1355

Please complete all sections of this form.

I am authorizing the person(s) named below to act as my personal representative regarding my personal health information, within the limits allowed by law and Medical Mutual policy. Complete all sections below, and sign and date.

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

Authorization for an Individual to Act on My Behalf:		
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.		
Last Name: *	**First Name: ***	**M.I.**
Address:	**City:**	
State: / **Zip:**	**Phone:**	

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
Attn: Cost Center 6200
2060 East Ninth Street
Cleveland, Ohio 44115-1355