



MEDICAL MUTUAL OF OHIO.
Your healthcare partner since 1934

WITHDRAW PREVIOUS AUTHORIZATION
PRIVACY & CONFIDENTIALITY REQUEST FORM

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

Check one of the following boxes to specify your request:

- Please revoke my previous authorization regarding confidentiality or naming an individual to act on my behalf. Complete general information and Section A, and sign and date.
I am authorizing the person(s) named in Section B to act as my new personal representative regarding my personal health information within the limits allowed by law and Medical Mutual policy. Complete all sections including your signature and date.

Your General Information *required information

Last Name*:
First Name*: Middle Initial:
Medical Mutual ID Number*: Birth Date (MM/DD/YY):
Group Number*:

Section A: Withdraw My Previous Request for Confidential Communication or Authorization Naming an Individual to Act on My Behalf

Please state your revoke request. If you are revoking the original Authorized Contact, include the full name of the contact.

Blank lines for providing revoke request details.

Section B: Authorization for an Individual to Act on My Behalf (Replace former contact, if desired.)

This individual will remain as authorized to act on your behalf until you notify Medical Mutual in writing of your intention to revoke this authorization.

Last Name*:
First Name*: Middle Initial:
Address:
City: State: Zip Code:
Phone Number:
Your 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 the back of your identification card.

Send completed and signed form to: Medical Mutual
P.O. Box 89499
Cleveland, Ohio 44101-6499