



MEDICAL MUTUAL OF OHIO.  
Your healthcare partner since 1934

**AUTHORIZED CONTACT REQUEST FORM**

**PRIVACY & CONFIDENTIALITY REQUEST FORM**

(MEMB)

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

**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\*: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

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\*: \_\_\_\_\_

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