



MEDICAL MUTUAL OF OHIO.
Your healthcare partner since 1934

COMPLAINT ON VIOLATION OF CONFIDENTIALITY OR PRIVACY
PRIVACY & CONFIDENTIALITY REQUEST FORM

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

Please complete all sections of this form.

I wish to file a complaint about a violation of my guaranteed privacy and confidentiality rights with Medical Mutual.

Your General Information

****required information***

Last Name*: _____

First Name*: _____

Middle Initial: _____

Medical Mutual ID Number*: _____ Birth Date (MM/DD/YY): ____/____/____

Group Number*: _____

Describe the circumstances of your complaint in detail, including dates, parties involved and alleged violation.

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