



MEDICAL MUTUAL OF OHIO.
Your healthcare partner since 1934

REQUEST ACCOUNTING OF DISCLOSURES

PRIVACY & CONFIDENTIALITY REQUEST FORM

(OPS)

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

Please complete all sections of this form.

I am requesting an accounting of certain disclosures of my personal health information made by Medical Mutual.

General Information

****required information***

Last Name*: _____

First Name*: _____ Middle Initial: _____

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

Group Number*: _____

Additional information required to complete requests

*Specify time period for which you request a listing of disclosures in the space below. (But not before April 14, 2003, as required by law.)

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