



MEDICAL MUTUAL OF OHIO.
Your healthcare partner since 1934

RESTRICTION ON USE OR DISCLOSURE OF INFORMATION
PRIVACY & CONFIDENTIALITY REQUEST FORM

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

Please complete all sections of this form.

I am requesting that my personal health information receive special treatment. I am requesting additional restrictions on my health information when used for treatment, payment, or other day-to-day operations. I understand that Medical Mutual is not required to agree to this restriction.

General Information *required information

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

To restrict use or disclosure of your personal health information when used for treatment, payment, or other day-to-day operations: Use the space below to describe your specific request. (Medical Mutual is under no obligation to agree to your request.)

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