MEDICAL MUTUAL®

Request for a Restriction on the Use or Disclosure of Protected Health Information

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

Please note: Items marked with an asterisk (*) are required.

Member Information			
Last Name*	First Name*	MI	Birthdate
Group Number	Member ID Number*		

Explanation for Request*

Please use the space below to explain your request to restrict use or disclosure of your protected health information when used for treatment, payment or other healthcare operations. (Note: Medical Mutual is under no obligation to agree to your request.)

Signature*	
Signature	Date

If you are an authorized representative, please sign below and enclose supporting documentation as required by state law (such as power of attorney, estate documentation or guardianship papers).

Signature of Authorized Representative	Relationship	Date

Please complete all sections above. Send the signed and completed form to:

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

Medical Mutual will review your request and notify you in writing of our decision.

For more information, see the Notice of Privacy Practices at MedMutual.com, or call the Customer Care number on your member identification card to request a copy.