MEDICAL MUTUAL®

Request for Accounting of Disclosures

I am requesting an accounting of disclosures of my protected health information made by Medical Mutual for reasons other than treatment, payment and health plan operations, as permitted and described in Medical Mutual's Notice of Privacy Practices. Medical Mutual is not required by law to provide an accounting of disclosures made before April 14, 2003.

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

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

Request Information*
Please specify the time period for which you are requesting a list of disclosures.

Signature*	
Member 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 provide you with a written response.

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.