# How to Request Copies of Your Protected Health Information (PHI)

**There may be times you need copies of your Protected Health Information (PHI) sent to you or a third party such as a family member or a doctor. PHI is any health information about you we keep in our records and could include your Medical Mutual plan details or specific claim information. To fulfill your request, Medical Mutual asks you to provide certain information.**

Follow these steps to request copies of your PHI:

### 1. Complete Request to Access Protected Health Information Form

Complete the form on the back of this page. The form provides Medical Mutual with the information necessary to access and release copies of the PHI you are requesting.

### 2. Return the Form and Documents to Medical Mutual

Mail the completed form, along with a copy of any necessary documents, to:

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

Or fax the completed form and documents to (800) 384-0921.

If you have questions about the Request to Access Protected Health Information Form, please contact Medical Mutual Customer Care at the number listed on your ID card.


C1766-COR R1/17

# Request to Access Protected Health Information


I am requesting access to my protected health information that Medical Mutual maintains in a designated record set.

**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 check the category of protected health information you want sent to you:

☐ Eligibility ☐ Claims ☐ Customer Care ☐ Medical

If you are requesting a record related to a phone call to Customer Care, include the date and time you called in the space below. If you are requesting information about a specific claim, include the claim number, date of service and name of the doctor or hospital in the space below.

**Delivery Information**

Please select where you would like the requested information sent:

☐ Yourself using the address on file with Medical Mutual **or** ☐ A third party using the address specified below

| Name | Address | |
|---|---|---|
| City | State | Zip |

**Signature***

| Signature | Date |
|---|---|

**If you are a legal 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 Legal 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

Or fax completed form to (800) 384-0921

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.