MEDICAL MUTUAL®

How to Give Permission to Release Your Protected Health Information (PHI)

There may be times you need Medical Mutual to share your protected health information (PHI) with family members or other individuals. PHI is any health information about you we keep in our records and could include your Medical Mutual plan details or specific claim information. We cannot release your PHI unless you grant us permission using the steps outlined below.

1. Complete the Release of Protected Health Information Authorization Form

Complete the form attached. The form grants Medical Mutual permission to release your PHI to the person or entity you list.

This form does NOT make someone your legal representative, thereby giving them decision-making authority.To do that, you must have legal documentation such as a power of attorney, estate documentation or guardianship papers. You can then use our Notification of Legal Representative Form to tell us about your legal representative.

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.

3. Notice for Medicare Advantage members

If you would like to designate a representative to communicate on your behalf about a claim, prior authorization, grievance, appeal, or any other Medical Mutual decision affecting your care or the services you receive, please complete the Appointment of Representative Form at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf, and mail to: Medical Mutual, Attn: P.O. Box 89499, Cleveland, OH 44101-6499.

If you have questions about this Release of Protected Health Information Form or the documents you must submit, please contact Medical Mutual Customer Care at the number listed on your ID card.

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Release of Protected Health Information Authorization Form

As required by the Health Insurance Portability and Accountability Act (HIPAA), Medical Mutual of Ohio and its subsidiaries (collectively known as Medical Mutual) may not use or disclose your protected health information except as provided in our Notice of Privacy Practices. Your signature on this form indicates you are giving permission for Medical Mutual to provide your protected health information to the person or entity named below. Please note: Items marked with an asterisk (*) are required.

Member Information (Person whose information will be released)

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

Information to be Disclosed*

- ☐ Full Disclosure—Any and all protected health information Medical Mutual maintains, including but not limited to mental health, HIV or substance abuse records
- ☐ Limited Disclosure—Select below to specify what information to share:
  - ☐ Application/enrollment information
  - ☐ Claim payment information
  - ☐ Health premium payment information
  - ☐ Medical information
  - ☐ Prescription drug information
  - ☐ Other—please specify. For example, you can provide a date range, or note a condition or treatment.

_____

Purpose of Disclosure*

What will this information be used for?

- ☐ To assist with questions about my plan.
- ☐ Other—please specify: _____

Legal Representative/Entity Information (Information will be disclosed to this person/entity)*

Name		
Street Address		
City	State	ZIP Code

Relationship

☐ Adult child ☐ Agent/broker ☐ Attorney ☐ Friend ☐ Organization ☐ Parent ☐ Sibling
☐ Spouse/domestic partner ☐ Other _____

Complete the form on the reverse side

I authorize the use or disclosure of my protected health information as indicated above by Medical Mutual to the above individual or entity.

This authorization will expire _____. If no expiration date or event is indicated, this authorization will expire when my enrollment in a Medical Mutual plan ends. I also understand I may revoke this authorization at any time by providing Medical Mutual with written notice of revocation at the address listed below. If I so revoke this authorization, it will not have any effect on any information released before revocation, including any action taken by the individual or entity that received the protected health information. Protected health information used or disclosed as instructed by this authorization may be further disclosed by the individual or entity receiving the protected health information and, therefore, no longer protected by HIPAA.

I understand I am under no obligation to sign this authorization. I further understand my ability to obtain insurance or eligibility for benefits will not depend in any way on whether I sign this authorization.

A copy of this Authorization Form is available to me or to my Legal Representative upon request.

Authorization	
Member Signature	Date
If you are a Legal Representative, please sign below and enclose supporting documentation as required by state law (e.g., power of attorney, estate documentation or guardianship papers).	
Name of Legal Representative	Relationship
Signature of Legal Representative	Date

For more information about your rights and how Medical Mutual uses your information, see the Notice of Privacy Practices at MedMutual.com, or call the Customer Care number on your member ID card to request a copy.

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

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

Or fax completed forms and documents to (800) 384-0921

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