inhealth
OHIO'S NONPROFIT
MUTUAL INSURER

Authorized Contact Request Form

PRIVACY & CONFIDENTIALITY REQUEST FORM

InHealth Mutual
501 West Schrock Road
Suite 310
Westerville, Ohio 43081

Please complete all sections of this form.

I am authorizing the person(s) named below to act as my personal representative regarding my personal health information, within the limits allowed by law and InHealth Mutual policy. Complete all sections below, and sign and date.

Your General Information: * Required Information

Last Name: *	**First Name: ***	**M.I.**
InHealth Mutual ID Number: *	**Birth Date (MM/DD/YY):**	
Group Number: *		

Authorization for an Individual to Act on My Behalf:

This individual will remain as authorized to act on your behalf until you notify InHealth Mutual in writing of your intention to withdraw this authorization.

Last Name: *	**First Name: ***	**M.I.**
Address:	**City:**	
State:	**Zip:**	**Phone:**

Closing:

Signature: *	**Date: ***

For more information, refer to the InHealth Mutual Privacy Notice located at inhealthohio.org or to receive a copy, call the Customer Service telephone number on your identification card.

Send completed and signed form to:

InHealth Mutual
Attn: Privacy Officer
501 West Schrock Road
Suite 310
Westerville, Ohio 43081