inhealth
OHIO'S NONPROFIT
MUTUAL INSURER

CORRECT / AMEND INFORMATION REQUEST

PRIVACY & CONFIDENTIALITY REQUEST FORM

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

Please complete all sections of this form.

I am requesting change to the health information stored by InHealth Mutual to correct an error or add information that has been left out of my record. I understand that information submitted by a medical doctor or health facility will need to be corrected by them.

Your General Information: * Required Information

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

Request Information:

To request an amendment to correct an error or add information omitted from your personal health information:

Attach a copy of the record you are requesting to be amended or corrected, and include an explanation supporting your request to correct or add information.

Closing:

Signature: *	**Date: ***

For more information, refer to the InHealthl 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

inhealthohio.org