REQUEST ACCOUNTING OF DISCLOSURES

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 an accounting of certain disclosures of my personal health information made by InHealth Mutual.

Your General Information: * Required Information

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

Additional information required to complete requests:

*Specify time period for which you request a listing of disclosures in the space below. (But not before April 14, 2003, as required by law.)

Closing:

Your 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

inhealthohio.org