Restriction on Use or Disclosure of Information

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 that my personal health information receive special treatment. I am requesting additional restrictions on my health information when used for treatment, payment, or other day-to-day operations. I understand that InHealth Mutual is not required to agree to this restriction.

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 restrict use or disclosure of your personal health information when used for treatment, payment, or other day-to-day operations: Use the space below to describe your specific request. (*InHealth Mutual is under no obligation to agree to your request.*)

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

Inhealthohio.org