inhealth
OHIO'S NONPROFIT MUTUAL INSURER

# Withdraw Previous Authorization

PRIVACY & CONFIDENTIALITY REQUEST FORM

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

**Check one of the following boxes to specify your request:**

☐ Please revoke my previous authorization regarding confidentiality or naming an individual to act on my behalf. Complete general information and Section A, and sign and date.

☐ I am authorizing the person(s) named in Section B to act as my new personal representative regarding my personal health information within the limits allowed by law and InHealth Mutual policy. Complete all sections including your signature and date.

## Your General Information: * Required Information

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

## Section A: Withdraw My Previous Request for Confidential Communication or Authorization Naming an Individual to Act on My Behalf

*Please state your revoke request. If you are revoking the original Authorized Contact, include the full name of the contact.*

## Section B: Authorization for an Individual to Act on My Behalf (Replace former contact, if desired)

*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