MUTUAL HEALTH SERVICES℠

MEMBER AUTHORIZATION RELEASE

PERSONAL HEALTH INFORMATION

Please complete all sections of this form.

Section A: General Information ***required information***

Last Name*: _____

First Name*: _____ Middle Initial: _____

Last 4 of Social Security Number*: _____ Birth Date (MM/DD/YY): _____ / _____ / _____

Group Health Plan ID Number*: _____ Group Number*: _____

Section B: Specific Information Regarding This Authorization

I authorize the use and/or disclosure of my personal health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed according to this authorization.

   _____

   _____

   _____

2. I authorize the following person (or persons) to make the authorized use and/or disclosure of my personal health information (name, title).

   _____

   The above named person's relationship to me is: _____

3. I authorize the following person (or persons) to receive my personal health information (name, title, etc.).

   _____

4. My personal health information may be used and/or disclosed for the following purposes.

   _____

5. I understand that, if my personal health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
6. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my personal health information have acted in reliance upon this authorization.
7. I agree a photocopy or facsimile copy of this authorization shall be accepted with the same authority as the original.
8. I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV – AIDS test results or diagnosis. I expressly consent to the release of such information.
9. I understand that if I do not sign this authorization, my refusal to sign will not affect my abilities to obtain treatment or payment under my policy terms, nor will it affect my enrollment or eligibility for benefits.
10. I understand that I have a right to inspect and copy my own personal health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R.164.524.
11. I understand that authorization for Mutual Health Services to use/disclose my personal health information will not result in direct or indirect compensation to Mutual Health Services, unless it is standard business practice.
12. This authorization expires 180 days from date of signature.

Your Signature* _____ Today's Date:* _____

If you are acting on behalf of the above named member as a legal representative, please provide the appropriate legal documentation (example: Power of Attorney.)

Send completed and signed form to: Billing and Enrollment Department, P.O. Box 5700, Cleveland, OH 44101; or fax to 330-666-3836 or email MHSAdmin@mutualhealthservices.com.

Multi-Language Interpreter Services & Nondiscrimination Notice

ATTENTION: If you speak one of the 15 languages listed below, language assistance services, free of charge, are available to you. Call 1-800-367-3762

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-367-3762.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-367-3762。

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-367-3762.

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-xxx-xxx-xxxx (رقم هاتف الصم والبكم: 1-800-763-2673).

Pennsylvania Dutch
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-367-3762.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-367-3762.

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-367-3762.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-367-3762.

Oromo
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-367-3762.

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-367-3762 번으로 전화해 주십시오.

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-367-3762.

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-367-3762 まで、お電話にてご連絡ください。

Dutch
AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-367-3762.

Ukrainian
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-367-3762.

Romanian
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-367-3762.


MUTUAL
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Nondiscrimination Notice

Mutual Health Services complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex in its operation of health programs and activities. Mutual Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex in its operation of health programs and activities.

- Mutual Health Services provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Mutual Health Services provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Mutual Health Services failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can contact:

Paul Mancino, Vice President, Assistant General Counsel & Deputy Compliance Officer

Medical Mutual of Ohio

2060 East Ninth Street

Cleveland, OH 44115-1355

Phone: (216) 687-2675

Fax: (216) 687-2623

Email: Paul.Mancino@MedMutual.com

You can file a grievance in person or by mail, fax or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- Electronically through the Office for Civil Rights Complaint Portal, available at:
  Ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, D.C. 20201-0004
- By phone at:
  (800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html


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