Participant Request For Confidential Communications

Participant Name: _____ Birth Date:___ /_____/___
Date

Address: _____
_____
_____

Home Telephone Number: _____ E-mail: _____

Participant Social Security Number:_____ _____

I, _____, am requesting that the Health Plan communicate with me in the alternative manner and/or location described below regarding my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996). Such restriction is necessary to prevent a disclosure that could endanger me. I understand that the Health Plan may deny this request if it imposes an unreasonable administrative burden.

Description of the Health Information that Must be Communicated Confidentially. The following is a description of the specific health information to which this request applies:

_____
_____
_____

Alternative Manner and/or Location. I request that the Health Plan only communicate with me in the following manner and/or at the location described below:

_____
_____
_____

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Signature Date

If signed by personal representative:
Name of personal representative: _____

Relationship to participant or nature of authority: _____

_____ _____/_____/_____
Signature of Personal Representative Date

Submit Form to: Privacy Official, 720 Market St., Suite 700, San Francisco, CA 94102