

Request for Confidential Communications

I. Individual Data:

INDIVIDUAL'S NAME: _____
GROUP HEALTH PLAN ID NUMBER: _____
ADDRESS: _____
TELEPHONE NO.: _____

II. Nature of Requested Restriction

A. I represent that *I could be endangered* if my GROUP HEALTH PLAN ("GHP") fails to communicate my protected health information by an alternative means or at an alternative location. _____ [*Please initial.*]

B. I request my GHP or its Business Associate to communicate with me regarding my protected health information in the following alternative manner or method.

At a telephone number other than my home number. The telephone number at which I should be contacted is: _____.

At a mailing address other than my home mailing address. The mailing address at which I should be contacted is: _____
_____.

Through my e-mail address, rather than my home address. My e-mail address for purpose of contacting me is: _____
_____.

Other. Please specify: _____.

III. Conditions Governing The Request For Confidential Communications:

Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), a Group Health Plan and its Business Associate are required to honor only *reasonable* Requests for Confidential Communications if a disclosure of protected health information could endanger the individual. A Group Health Plan/Business Associate may condition granting the request for *reasonable* accommodation upon the following:

- A. Individual providing information concerning how premiums or other payments will be handled; and
- B. Individual specifying an alternative address or other method of contact.

INDIVIDUAL SIGNATURE: _____

INDIVIDUAL NAME (Please Print): _____

GHP/BUSINESS ASSOCIATE TO COMPLETE THE FOLLOWING:

The Request for Confidential Communications has been reviewed by the Group Health Plan/Business Associate and is:

- Accepted* Denied (Request cannot reasonably be accommodated)

Date Restriction Becomes Effective: _____.

Comments: _____

Signature of GHP/Business Associate Representative: _____

Date: _____