CONFIDENTIAL COMMUNICATIONS REQUEST
(Health Plan)

Purpose: This form is used for an individual's request that we use alternative means or an alternative location when communicating about protected health information.

SECTION A: Individual requesting confidential communications.

Name: _____

Address: _____

Telephone: _____ Identification Number: _____

SECTION B: To the individual—please read the following and provide the information requested.

You have the right to request that we communicate about your protected health information by alternative means or to an alternative location to avoid endangering you. We will accommodate your request if (a) it is reasonable, (b) you state clearly that failure to communicate your protected health information by the alternative means or to the alternative location could endanger you, and (c) you provide reasonable alternative means or location for communicating with you. We will not investigate the validity of your claim that failure to communications with you by the alternative means or location could endanger you.

☐ I request that you communicate with me about my protected health information by alternative means. (Please provide full information on the alternative means you want us to use)

_____

_____

☐ I request that you communicate with me about my protected health information at the following alternative location. Please provide full information on the alternative location:

_____

_____

INDIVIDUAL'S SIGNATURE.

I attest that failure to communicate my protected health information by the alternative means or to the alternative location I request could endanger me.

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.
PLEASE RETURN THIS FORM TO:
Planned Administrators, Inc
PO Box 6927
Columbia, SC 29260
Attention: Privacy Coordinator