CONFIDENTIAL COMMUNICATION REQUEST FORM

Complete this form to receive all communications that disclose medical information or provider name and address related to receipt of medical services at an alternative address or by alternative means.

Covered individual requesting confidential communication:

Name: ____

Medical Record Number: ____________________________ Date of Birth: ____________________

Address: ____

City: ____________________________State: _______ Zip Code: ________________

Email Address (if applicable): ________________________________

Phone Number: ___________________________

Please send all future communications to the address provided below:

Alternative Address: ____

City: ____________________________State: _______ Zip Code: ________________

Alternative Email Address (if applicable): ________________________________

Phone Number: ___________________________

Alternative method of communication (if applicable): _____________________________________

How would you like to be contacted if we have questions about this request?

____

☐ I understand this request will remain in effect until I revoke the request or submit a new request.

Signature: ____ Date: __________________________

Please return the completed and signed request to:

Kaiser Foundation Health Plan, Inc. PO Box 939001, San Diego, CA 92193-9001.