KAISER PERMANENTE®

CONFIDENTIAL COMMUNICATION REVOCATION REQUEST FORM

Complete this form to discontinue delivery of confidential communications at the alternative mailing address, telephone number, or email address previously provided.

Covered individual requesting to discontinue confidential communication:

Name: _____

Medical Record Number: _____ Date of Birth: _____

Current Alternative Address on file: _____

City: _____State: _____ Zip Code: _____

Current Alternative Email Address on File (if applicable): _____

Phone Number: _____

Please send all future communications to the address provided below:

Address: _____

City: _____State: _____ Zip Code: _____

Email Address (if applicable): _____

Phone Number: _____

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

_____

☐ I understand this is a request to discontinue confidential communication from being sent to my alternate address.

Signature: _____ Date: _____

Please return the completed and signed request to:

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