



CONFIDENTIAL COMMUNICATION REQUEST

Purpose: This form is used for an individual’s request that, to avoid endangering the individual, we use an alternative location when communicating protected health information.

SECTION A: Individual requesting confidential communication.

Name: _____

Current Address: _____

Member Identification Number: _____ Birthdate: _____

Relationship to Subscriber: _____

SECTION B: To the Individual—Please read the following and complete the information requested.

You have the right to request that we communicate your protected health information using an alternative location to avoid endangering you. We will accommodate your request if it is reasonable and you state clearly that failure to communicate your protected health information to the alternative location could endanger you.

We will begin communications to the alternative location within five (5) business days of our receipt of this signed document. Any communications prior to this date will be sent using the existing address information.

When applicable, we will revoke any authorization we have on file to release your protected health information that you had given us prior to your request for confidential communications. You may submit a new authorization(s), if you choose, using the alternative location.

This form is valid only for the identification number and individual specified above. If your identification number changes, you will be required to submit a new request for confidential communication. If additional members require alternate communication, you will be required to complete and submit a form for each member. If you have multiple coverages, you will be required to complete and submit a form for each coverage. This form only applies to communications from us and does not apply to communications you may receive from other entities.

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:*

In care of (optional): _____

Alternate Address: _____

City: _____ State: _____ Zip Code: _____

Alternate Phone Number: _____

INDIVIDUAL’S SIGNATURE

I attest that failure to communicate my protected health information using the alternative location could endanger me.

Signature: _____ Date: _____

If this request is from a personal representative on behalf of the individual, complete the following (*please print*):

Personal Representative’s Name: _____

Relationship to Individual: _____

PLEASE TAKE A COPY OF THIS FORM FOR YOUR RECORDS.

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