COMMUNITY
CARE HEALTH

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and the California Confidentiality of Medical Information Act, you may request that Community Care Health (CCH) and its business associates communicate with you using an alternate address or other means of contact. You may use this form to make this request and mail it to us at the address on the following page. You may also send us an email with all of the below information to: customerservice@communitycarehealth.org. If you send your request by email, please include the words "Request for Confidential Communications" in your email subject line.

CCH will make every effort to comply with your request. We will notify you if your request cannot be reasonably accommodated. If accepted, we will implement your request within 14 days of receipt by U.S. mail or within 7 calendar days of receipt by email.

If you wish to change or revoke this request, you must submit a new Request for Confidential Communications or write to us.

If you have any questions regarding the process to request confidential communications, please contact Customer Service at 855-343-2247.

Please complete the following:

Member Name: _____

Member ID # as shown on your CCH ID card: _____

Member Date of Birth: _____/_____/_____
Mo Day Yr

Indicate below the alternative address where you prefer we send correspondence:

_____
Street or PO Box

_____ _____ _____
City State Zip

Indicate below the phone number and/or email you prefer we use to contact you:

Phone Number: (_____) _____-_____

Email: _____

If applicable, please provide below any additional information regarding the form or format in which you would like us to communicate with you. We will provide the information if it is readily producible in the form or format you request.

_____

Provide your name, signature and date:

_____
Print Name

_____ _____
Signature Date

_____
Relationship to Member*

* If you are not the Member or parent of the Member, please include proof of your legal authority to act on behalf of the Member specifically for matters related to the Member's health. You may submit one of the following or other legal document.

- ✓ HIPAA Authorization
- ✓ Power of Attorney for Health Care
- ✓ Legal Guardianship documentation from court or other authorized agency

Send this form to:

Community Care Health
ATTN: Privacy Officer
PO Box 45026
Fresno, CA 93718