Confidential Communication Request Form

As an Alameda Alliance for Health (Alliance) member, you have the right to choose how we contact you about your healthcare. This includes your protected health information (PHI). We can contact you securely by mail, email, or phone.

If sharing your health information could put you in danger, we can keep it private. You do not need to show proof of being in danger.

If you are 12 years of age or older and getting care for sensitive health needs, you can ask to keep this information private. Sensitive services include things like:

- Mental health care
- Treatment for alcohol or drug use
- Pregnancy care or birth control
- Care for having a baby
- Testing for sexually transmitted infections (STIs)

For these services, the Alliance will not send an Explanation of Benefits (EOBs) to the main person on the health plan (policyholder).

To request confidential medical communications, you must submit this form via mail, fax, or email:

Mail: Attn: Member Services Department
Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502

Fax: **1.877.747.4504**
Email: **memberservices@alamedaalliance.org**

Please note: You may change or cancel your request at any time by submitting a new form.

Section 1: Member Information

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____

Alliance Member ID Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Section 2: How to receive confidential communication

I request that communications that have confidential (private) information be sent to me by (please select all that apply):

☐ Mail to this preferred address:

Address: _____

City: _____ State: _____ Zip Code: _____

☐ Email to: _____

☐ Phone by calling: _____ ☐ Home ☐ Cell

Section 3: Signature

By signing below, I confirm that the information given in this form is true and correct. I understand that this request changes how the Alliance contacts me. This form of contact will stay the same until I cancel it or submit a new Alliance Confidential Communication Request Form.

If you are signing for the member, please describe your relationship below. If you have been appointed by a court or legal process as the member's personal representative, please send us copies of the legal forms (such as a power of attorney or an order of guardianship).

Signature: _____ Date: _____

Relationship (if signing for the member): _____

This form complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Centers for Medicare & Medicaid Services (CMS)/Dual Eligible Special Needs Plans (D-SNP), the California Department of Health Care Services (DHCS) contractual requirements, and applicable California confidentiality laws, including the Confidentiality of Medical Information Act (CMIA) and Health & Safety Code §1364.5.