KAISER PERMANENTE®

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.