

# CONFIDENTIALITY REQUEST FORM

**You have the right** to have protected health information\* sent to you instead of the person who pays for your health insurance plan. In Washington state, sensitive health care services\*\* are required to be confidential, but if you have not requested this information to be sent to a different address or by another means, this information will be sent in your name to the address on file. You can ask to be contacted about protected health information and sensitive health services:

- At a different mailing address.
- By email.
- By phone.
- Through the health insurance company's portal.

To make this request, complete, sign and send this form to your health insurance company, or you can call your health insurance company to request confidentiality. You can also use this form to change or update your confidential contact information.

**Please note:** Your health insurance company must complete your request within three business days of receipt.

\_\_\_\_\_  
Name of your health insurance company

\_\_\_\_\_  
Your name

\_\_\_\_\_  
Your date of birth

\_\_\_\_\_  
Your insurance member # (if available)

\_\_\_\_\_  
Your insurance group # (if available)

Tell us how we should contact you. Some laws may require certain communications to be in writing, so please provide an email or mailing address to ensure confidentiality. Your health insurance company must contact you through at least one of your chosen communication methods. In the boxes below, please rank your choice by putting a "1" next to your first choice, "2" next to your second choice, if you select more than one method of contact.

- Email at this email address: \_\_\_\_\_
- U.S. mail at this address: \_\_\_\_\_
- Message through online insurance patient portal.
- Phone call to the following number: ( ) \_\_\_\_\_
- Send to my authorized health care provider or representative: provide name & contact information: \_\_\_\_\_

## **IMPORTANT! The following section MUST be completed:**

- Please provide a phone number or email address to contact you if there are questions regarding this request.

( ) \_\_\_\_\_

Phone number

Email address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**PLEASE NOTE:** If you change insurance companies, you will need to make this request to the new company. Until your request is processed, the health insurance company may continue to send your protected health insurance to the person who is paying for your health insurance.

\*Protected health information means individually identifiable health information your company has or sends out in any form. Confidential communication of protected health insurance covered under this request includes:

- Bills and attempts to collect payment for health care services from your health insurance company (however, this request does not apply to your health care provider).
- A notice of adverse benefits determination.
- An explanations of benefits notice.
- A request for additional information about a claim.
- A notice of a contested claim.
- The name and address of a provider, a description of services provided, and other visit information.
- Any written, oral or electronic communication that contains protected health information.

\*\*Sensitive health care services are health care services related to:

- Reproductive health care.
- Sexually transmitted diseases.
- Substance- use disorder.
- Gender dysphoria.
- Gender-affirming care.
- Domestic violence.
- Mental health.