

# Oregon Request for Confidential Communication

---

You have the right to have protected health information\* sent to you instead of the person who pays for your health insurance plan.

**You can ask to be contacted:**

- At a different mailing address
- By email
- By telephone

**To make this request, complete, sign, and send this form to:**

- Kaiser Foundation Health Plan of the Northwest  
Attn: Membership Administration  
500 NE Multnomah St., Floor 4  
Portland, OR 97232
- Fax: 855-524-5257
- Email: **NW.Membership.Administration@kp.org**

**\*Protected Health Information (PHI).** PHI is individually identifiable information (oral, written, or electronic) about a member/patient's physical or mental health, the receipt of health care, or payment for that care. Examples include an explanation of benefits, a claim denial, or appointment information.

**Please note:** It can take up to 30 days from the date Kaiser Foundation Health Plan of the Northwest receives your hard-copy request to process it. Requests made by telephone, by email, or over the internet must be implemented by your insurer within seven days of receipt.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Health Record Number (HRN)

Please tell us how we should contact you. If you mark more than one way, put a "1" next to your first choice, "2" next to your second choice, and so on. Your health plan must contact you through at least one of the communication methods noted below:

Email to the following email address: \_\_\_\_\_

U.S. Mail at this address: \_\_\_\_\_

Text to the following phone #: \_\_\_\_\_

Message through online insurance patient portal: \_\_\_\_\_

Phone call to the following number: \_\_\_\_\_

**IMPORTANT! The following two sections MUST be completed:**

1. If a communication cannot be sent in the above selected formats, or if you want information by U.S. mail, provide the address below:  
\_\_\_\_\_

2. Is there a phone number or email to use if there are questions regarding this request?  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

