KAISER PERMANENTE®

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 information 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.

***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.

****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.

To make this request, complete, sign, and return this form to:
Mail: Kaiser Foundation Health Plan of Washington, Attn: Member Services, P.O. Box 34590 Seattle, WA 98124
Fax: 1-888-874-1765

1. Member Information

First name _____ Last Name _____

Date of Birth _____ Member ID _____ Group Number _____

2. Please 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. 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:

☐ U.S. Mail at this address: _____

☐ Email to the following email address: _____

☐ Message through online insurance patient portal (KP MyChart): _____

☐ Phone call to the following number: _____

3. Please read this before you sign and send

This confidential communication request does not apply to your healthcare provider. You must give them separate, specific instruction about what healthcare information they may share, and with whom. This request stays in effect until you notify us in writing that it is terminated or revoked. Your health plan may have already shared health information before it received this request, and that disclosure cannot be changed. Your health plan and its representatives are not required to comply with this request if a court order or court document prohibits us from following your directive.

We will act upon your request within 3 business days of receiving it from you. You may also call us at 1-888-901-4636 to provide us with this direction.

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 _____

4.Signature

Signature _____ Date _____