KAISER PERMANENTE® *HAWAII REGION*

Request for Confidential Address for Clinical and Health Plan Communications

Original: **Revised:**

MR#:

Name:

Sex/BD:

Print Legibly with Black Ball Point Pen. Dates require a full year (YYYY).

Purpose:

Under the federal privacy rule (HIPAA) you have the right to ask that we send your health information, such as appointment reminders, billing statements or results, to a different address or that we contact you at an alternate phone number. This right is called confidential communication. Kaiser Permanente (KP) will accommodate reasonable requests from members to receive such confidential communications.

Instructions:

This form must be submitted in person at a KP patient service facility. A valid picture ID is required for verification at the time of submission. If this form is signed by persons other than the patient, documentation proving your legal authority to act on behalf of the patient is required.

Confidential Request Types (please read carefully and select all that apply to your request):

☐ **Confidential Clinical Communications**

Address to be used for all clinical mailings, including test results, screening test mailers, mailed appointment reminders, surveys and explanation of benefits reports.

- All clinically related communications/explanation of benefits addressed to me will be sent to the confidential address during the time period requested.
- If I have given proxy access to my kp.org account to another individual I will need to discontinue the proxy's access myself. This request will not terminate such access.
- Confidential addresses must have a start and end date. If no end date is provided, the address will be effective for one month from the start date. To continue confidential clinical communications once the end date has passed I must submit a new form.
- We strongly recommend providing us with an Alternate Phone Number (different from your residential phone) in case we need to contact you regarding services received as part of the confidential visit.

Address: _____ **Apt:**_____

City: _____ **State:** _____ **Zip:** _____

Alternate Phone Number ( ) _____ - _____

Effective Date: ____/____/_____ **End Date:** ____/____/_____ *(cannot exceed one year from today's date)*

☐ **Confidential Billing Statements**

Address to be used for bills and statements related to a particular visit/encounter/service. I understand:

- I must request confidential billing statements on or before **EACH** visit.
- My confidential services may be indirectly reflected on reports sent to the subscriber, such as communications about plan deductibles or co-payments (cost share).
  - ❖ If I do not want this information to appear on communications to the subscriber, I understand that I must request a Self-Pay Account, pay for all services in full, and complete the HIPAA Restriction Request Form.
- I will not receive automated telephone reminders for this appointment.
- I am responsible for payment of any applicable co-payments or cost-shares for these visits.

Address: _____ **Apt:**_____

City: _____ **State:** _____ **Zip:** _____

Patient Signature: I understand:

- Communications with me at this confidential address/phone number are subject to the conditions above.
- The confidential address provided must be valid. If my confidential address changes, I must notify KP and complete a new form.
- If any information on this form is incomplete, my request may be rejected.
- If I have any questions I can contact Customer Service between 8 am to 5 pm (M – F) at:
  Oahu (808)432-5955 Neighbor Islands (800) 597-5955

_____ X _____ ___ | ____ | ____

Print Name Signature Date

Relationship to patient: ☐Patient/Self ☐Parent/Legal Guardian ☐Teen (14-17) Protected Services ☐Other_____

This section for Kaiser Permanente use only

1. Verify understanding of form with patient.
2. If patient requested a Self-Pay Account, follow HIPAA Restriction workflow (requires patient to complete form *Request to Restrict Disclosure of Health Information to Insurance Company*)
3. Set up Confidential Guarantor when applicable.
4. Date: _____|___|_____ Comments: _____
5. Received By *(print name)*: _____ Dept/Loc: _____ Ph#: _____
6. Fax completed form ASAP to Patient ID (432-5050) and send via interoffice mail.