

**CONFIDENTIAL COMMUNICATION REQUEST
(Health Plan)**

Purpose: This form is to be used by an individual who wants TRIPLE-S SALUD to send his Protected Health Information, in a confidential, through alternate means or an alternative location.

SECTION A: Individual requesting confidential communication.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Contract Number: _____ Social Security Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

You have the right to request that we communicate all or part of your protected health information in confidence by alternative means or to an alternative location. We will accommodate your request if (a) it is reasonable, (b) you represent that failure to communicate your protected health information in confidence by the alternative means or location could endanger you, (c) you provide reasonable alternative means or location for communicating with you, and (d) you provide a satisfactory explanation on how any applicable premium and other payments will be handled under the alternative means or location you request. To exercise this right, please complete Section B.

SECTION B: Confidential Communications Requested.

Could failure to communicate your protected health information in confidence by the alternative means or to the alternative location you specify endanger you? () Yes () No

Please describe the protected health information you want to make subject to confidential communication:

Please explain how any applicable premium and other payments will be handled:

☐ I request that you communicate with me by the following alternative means. Please provide full information on the alternative means you want us to use:

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- ☐ I request that you communicate with me at the following alternative location or address.
Please provide full information on the alternative location:

INDIVIDUAL'S SIGNATURE

I attest that failure to communicate about my protected health information by the alternative means or to the alternate location I request could endanger me.

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.