REQUEST FOR CONFIDENTIAL COMMUNICATION

THIS FORM WILL ALLOW ME, AS A CITY OF HOUSTON SELF-INSURED MEDICAL GROUP HEALTH PLANS CUSTOMER, TO REQUEST TO RECEIVE COMMUNICATIONS OF PROTECTED HEALTH INFORMATION (PHI) ABOUT ME BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS

If a request is made for an alternative location, I understand correspondence will continue to be addressed to me, but will be mailed to the address I provide below. I understand all Customer correspondence to me will be mailed to this alternative address whether or not it contains any confidential information about me. I understand that this request may be denied if it cannot reasonably be accommodated.

Note: If your request is granted, it will affect only written and oral communications by City of Houston Self-Insured Medical Group Health Plans. If you also wish your employer, a group health plan, physician or anyone outside City of Houston Self-Insured Medical Group Health Plans to make this change, you must obtain their agreement separately.

VERIFICATION – (Please Print)

Identification of Customer: (The following information is needed for verification. Please complete all applicable items).

Name of Customer: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Employee ID No.: _____

Group or Account No. on ID Card: _____

Subscriber Name (if different from Customer): _____

Subscriber Relationship to Customer: _____

REQUEST

1. I request to receive communications of my PHI from City of Houston Self-Insured Medical Group health Plans:

   ☐ By alternative means or location (Please describe and provide address): _____
   _____

   Reason why the alternative means or location is necessary: _____
   _____

2. Restriction request: (Please indicate by checking the item below.)

   ☐ I wish to deny other family members covered under my policy access to my PHI via phone and Internet. Note - If you make this election and you are not the Subscriber, you will not be able to access your information on the internet. You will need to call the number on your or the Subscriber's ID card to obtain information by phone. *(The subscriber will still be able to obtain his/her own PHI via phone and Internet.)*

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The City of Houston Self-Insured Medical Group Health Plans will not disclose confidential information without your authorization unless it is necessary to provide your health benefits, administer your benefit plan, to support the City of Houston Self-Insured Medical Group Health Plans programs or services, or as otherwise required or permitted by law. We will not, for example, give your confidential information to a credit agency, a telemarketer, or a prospective employer. We will not sell, rent or license the confidential information you provide to us. You do not need to request a restriction if you are concerned about those uses and disclosures.

VERIFICATION QUESTIONS – (Required for Request #2 only)

The answers you provide will be used to verify your identity if you call for your PHI. You must answer these questions if you checked box #2 in the Request section above. Note that we ask these questions because the answers should be easy for you to remember, but you may enter other numbers as described below

4 digit PIN (you may use any four digit number): _____

What is your mother's date of birth: (answer in the following 8-digit format:11231949 for November 23, 1949) _____ _____. (You may use any date, however, it cannot be a future date, it must be a legitimate calendar date. For example, we cannot accept 11361949 (November 36, 1949) because there are not 36 days in November. We also cannot accept 11232015 (November 23, 2015) because 2015 is a future date.)

- Please DO NOT provide anyone else with the answers to these questions.
- You should keep a copy of this form.

PLEASE NOTE

- *If you are not the Subscriber, any check payment for services you receive that is not sent to the health provider will be* sent *to the Subscriber. Therefore, a Subscriber may receive a check that may prompt questions to you about the services rendered.*
- *If the Subscriber is enrolled in a Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA), he/she will also receive an EOB for any claim submitted for reimbursement. In many cases, claims submitted for payment by the Subscriber's health benefit plan will be automatically submitted to his/her FSA or HRA for reimbursement.*
- *Communications containing your PHI will be sent to the address you have provided on this form.*
- *If an alternate address is approved, it may be shown on correspondence that the City of Houston Self-Insured Medical Group Health Plans sends to others, such as your provider.*
- *If the information on this form is not complete, the City of Houston Self-Insured Medical Group Health Plans will return the form to you, and this request may not be considered until the City of Houston Self-Insured Medical Group Health Plans receives complete information.*
- *If your Customer ID or date of birth is changed, another form will need to be completed at that time.*
- *If either the Customer or Group changes to a different type of health care benefits coverage provided by the City of Houston Self-Insured Medical Group Health Plans, another form will need to be completed at that time.*
- *You may change or revoke this request by sending a written request to the City of Houston Self-Insured Medical Group Health Plans, at the address on page 3. You can obtain a Change/Revoke form by calling the City of Houston Self-Insured Medical Group Health Plans at the number on your City of Houston Self-Insured Medical Group Health Plans ID card.*

Please Complete Form On Next Page

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SIGNATURE AND NOTARIZATION

To safeguard your privacy and help make sure no one else is requesting access to your PHI, this request must be notarized. (*Notary services can often be provided free at a bank where you have an account).*

I have read and understand the above information:

Print Name _____ Date: _____

Signature of Customer, Parent/Guardian, Personal Representative: _____

Relationship, if signed by other than Customer: _____

Note that, if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If Customer is unable to give consent because of age, complete the following: Customer is a minor _____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

State of)
) SS.
County of

On this the _____ day of _____, 20_____ , before me, _____ (Notary Public), the undersigned officer, personally appeared _____ (member or legal rep. name), known to me (or satisfactorily proven) to be the person whose name is subscribed to the writing instrument and acknowledges that (s)he executed the same for the purposes therein contained.

In witnesses thereof I hereunto set my hand:

_____
Notary Public

My Commission expires: _____

Please Return This Completed Form To:
Privacy Officer
City of Houston Self-Insured Medical Group Health Plans,
Human Resources Department, 611 Walker, 4th Floor, Houston, Texas 77002
Email: PrivacyOfficer@houstontx.gov; FAX: 832.393.7208