Confidential Communications Request

As required by HIPAA and California law, you have a right to request communications of your protected health information/medical information from Molina Healthcare in a specific form and format or at other locations. We will accommodate your Confidential Communication Request consistent with the law. Please note that only Protected Individuals may ask for confidential communications of their medical information relating to their receipt of sensitive services*. This form allows you to tell us how you would like to get your PHI/Medical Information. You can also tell us the address at which you would like to get your PHI/Medical Information.

**"Sensitive services" means health care services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the California Family Code, and Sections 121020 and 124260 of the California Health and Safety Code*

PLEASE PRINT:

Member Name: _____ Date of Birth: _____

Address: _____

_____

Member ID#_____ Phone: _____

I want to request the use of the below form/format or other locations to receive communications of my Protected Health Information (PHI)/Medical Information.

This request applies to the following Protected Health Information (PHI)/Medical Information about me:

_____

_____

This request supersedes any prior request for confidential communications I may have made.

Please select all that apply:

☐ **Phone**

I want you to contact me by phone at: ☐ Home: _____ ☐ Cell: _____

Leave messages on my answering machine: ☐ Do ☐ Do not

Leave messages with any other person: ☐ Do ☐ Do not

☐ **Mail**

I want you to contact me at the below address:

_____

_____

☐ **Email**

I want you to contact me at the following email address: _____

Please send your completed form to Molina Healthcare at <u>one</u> (<u>1</u>) of the following:

Fax	(844) 834-2155
Mailing Address	Molina Healthcare **Attn:** Service Fulfillment 200 Oceangate Ste 100 Long Beach CA 90802

_____ _____

Signature of Member or Member's Personal Representative | Date

_____ _____

Printed Name of Member's Personal Representative, if applicable | Relationship to Member or Personal Representative's Authority to act for the Member, if applicable

For Molina Healthcare:

Date Received: _____ Date Cancelled or Modified: _____