Return To: CountyCare Health Plan
P.O. Box 211592
Eagan, MN 55121

PROTECTED HEALTH INFORMATION (PHI) COMMUNICATION REQUEST

Use this form to request that CountyCare either:

- Restrict the use or disclosure of your PHI for treatment, payment, or health care operations purposes, as well as for disclosure of your PHI to a family member, relative, or others involved in your care (Complete Sections I, II and IV); or
- Provide your PHI by alternative means or at alternative locations - e.g. an address other than the member address on file. (Complete Sections I, III and IV).

This request will not be considered until CountyCare receives all the information requested in this form. If your request is granted, it will only affect disclosures made by CountyCare, or entities working on behalf of CountyCare. If your request is granted, it will remain in effect until you change or revoke it. If you need assistance completing the form, please contact the Customer Service number at **312-864-8200**.

I. MEMBER INFORMATION: (individual who is the subject of the PHI communication request)

Name: _____

Address: _____

Member ID #: _____ **Date of Birth:** _____

II. REQUEST TO RESTRICT THE USE OR DISCLOSURE OF YOUR PHI:

☐ **I request that CountyCare Health Plan restrict uses and/or disclosures of my PHI in the following way(s):**

Please list the types of PHI that you would like restricted (for example, information about testing or treatment related to specific diseases, mental health records, substance abuse records, etc.):

Please list the names of the individuals that you would like this restriction to apply to (for example, specific family members, friends, or those involved in your care):

III. REQUEST FOR ALTERNATIVE COMMUNICATIONS OF YOUR PHI:

- CountyCare will accommodate your request to receive PHI by alternative means or at alternative locations if all of the following criteria are met:
  - » Your request is reasonable;
  - » You clearly indicate that our failure to honor this request could put you in danger; and
  - » You provide a location or another reasonable alternative for us to communicate with you.
- Your request may be denied if it cannot reasonably be accommodated.

☐ **I request to receive certain communications from CountyCare by alternative means or sent to an alternative location.**

Please list the types of communications that you would like the request to apply to:

Please list your alternative address or other means of contact:

Will the failure to communicate your PHI through an alternative location endanger you? If you select "no", please call the customer service at 312-864-8200, Option 1 to request an address change.

☐ **Yes** ☐ **No**

IV. SIGNATURE

I request that CountyCare either restrict the use/disclosure of my PHI or provide my communications in an alternative means, as specified in Sections II and III above. I have read and understand the above information.

The member must sign this form to authorize us to process his/her request. If the member cannot sign, only the member's legal representative may sign. If you are the member's legal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship). Members 18 years or older must sign the form on their own behalf.

Signature of Member: _____ Date: _____

Signature of Representative (if applicable): _____

Relationship to the Member: _____

FOR COUNTYCARE USE ONLY

Date request received: _____

Member notified in writing of decision on this date: _____

Date request revoked by Member (if applicable): _____

Name of staff member processing request: _____