

**NORTHWESTERN HEALTH SCIENCES UNIVERSITY HEALTH
PLAN
REQUEST FOR CONFIDENTIAL COMMUNICATIONS**

You have a right to request that the Health Plan provide alternative means or alternative locations for you to receive communications of your protected health information (“PHI”). We must agree to your request for a confidential communication **only** if (1) you provide a reasonable alternative means or locations for the communication, and (2) you believe that a disclosure of the information could endanger you.

Please submit this form to: **Northwestern Health Sciences University
Deborah Hogenson, Health Plan Privacy Officer
Attn. Human Resources
2501 W. 84th St.
Bloomington, MN 55431**

Your Name: _____

Address: _____

**Daytime phone
number:** _____

Please select one :

___ I participate in or am covered under the following Health Plan:

___ Medical

___ Dental

___ Section 125 Medical Reimbursement

___ I am the personal representative of an individual participating in or covered under the following Health Plan (*please attach completed Designation of Personal Representative form*).

___ Medical

___ Dental

___ Section 125 Medical Reimbursement

My request for confidential communications from the Health Plan applies to the following types of communications (list):

(If more space is needed, please attach a separate sheet)

The communications identified above should be made to me in the following manner (please provide an alternative address, telephone number, or e-mail address):

Please Read Carefully and Sign

I believe that disclosure of my PHI in the communications described above could endanger me. I understand that the Health Plan is not required to agree to my request for a confidential communication if I do not provide a reasonable alternative means for the communications or if I do not believe that the disclosure of information in the communication will endanger me.

Signature

Date

For office use only:

Received by: _____ Date: _____