Request for Restriction on Manner or Method of Confidential Communications Form

Member Name: _____

Member CIN: _____ Date of Birth: _____

Address: _____ Phone Number: _____

You may request to receive confidential communications of Protected Health Information (PHI) by different ways or to a different address. For instance, you may not want your health records or your member information to be sent to your home where a family member might see it.

We will agree to these requests when there is a risk of personal harm to you because of Protected Health Information (PHI) sent from CalOptima.

☐ **I request CalOptima NOT to send any communications regarding my Protected Health Information (PHI) to the address or telephone number provided above.**

The other address or method of reaching me is (you must provide an alternate address in order for CalOptima to abide by your request for confidential communication):

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

YOUR RIGHTS:

To learn more about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also found on our website: www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523** or toll-free at **1-800-735-2929**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima by calling **1-714-246-8500** or write to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights.

SIGNATURE:

Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____