

Confidential Communications Request Form



Community Health Plan of Imperial Valley wants you to know that you have a choice about your protected health information (PHI). You can have Community Health Plan of Imperial Valley send any communication that has PHI directly to you.

California law states: "Sensitive Services means: all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence."


PHI is health information about you. Examples of communications that include PHI are:


- Information about your appointments.
- Claim denials, requests for more information about claims, and alerts of contested claims.
- The name and address of your provider, descriptions of services provided and other visit information.

Note: If you are over the age of 12, you do not require approval from your parent, guardian, or personal representative to make the Confidential Communication Request.

Complete this form if you'd like us to send communications that contain PHI straight to you. Communications will be sent to a separate mailing or email address. (**Please note**, not all communication can be sent to you via email).


Please mail or fax this finished form to Community Health Plan of Imperial Valley.
Allow up to 14 days for us to process your request.

 **Mail:** Community Health Plan of Imperial Valley – Privacy Office
PO Box 9103, Van Nuys, CA 91409-9103

 **Fax:** (818) 676-8314, Attention: Community Health Plan of Imperial Valley
Privacy Office

We're here to help!

Please call or email us if you have questions.

 **Phone:** Refer to the phone number on the back on your member ID card.

 **Email:** Privacy@HealthNet.com. Attention: Community Health Plan of Imperial Valley

Tip!

If you change your enrollment to another plan, you will need to complete this form again under your new member ID Number.

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Your information:		
First name:	Last name:	Birthdate:
Subscriber ID number:	Phone number: <i>Where to call you if we have questions?</i>	
Yes! Please send communications with my PHI to this mailing address and/or email address:		
Mailing address:		
City:	State:	ZIP:
Email address:		
I certify and acknowledge that the above information is true and correct:		
Signature:	Date:	

Note: The Confidential Communications Request shall be valid until the member submits a revocation of the request or a new Confidential Communications Request is submitted.

If you are signing for the member, describe your relationship below. If you are the member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

I certify and acknowledge that the above information is true and correct:	
Personal Representative Name: (Please print)	
Describe the relationship:	
Relationship to the member: (Please print)	
Personal Representative Signature:	
Signature:	Date: