SAN JOSÉ STATE UNIVERSITY

PART I - REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF PERSONAL HEALTH PLAN INFORMATION

HUMAN RESOURCES

Employee Support Services | One Washington Square | San José, CA 95192-0046 408-924-2250 | 408-924-2284 (fax)

Instructions:

- *Please complete part I and return form to: Campus Privacy Contact Rick Casillo at the address above. If you have any questions you may contact Rick at (408) 924-2149.*
- *Please print in ink.*

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations. If the Payment of benefits is affected by this request, the Plan may also deny this request unless you contact the Privacy Official to discuss alternative Payment means.

EMPLOYEE INFORMATION		
1. Employee Name:	1a. Employee ID Number:	1b. Employee Date of Birth:
1c. Employee Health Plan ID Number:	1d. Department/College Name:	
2. Name of Person Whose Records you are Requesting:	3. Your Name:	
2a. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other (please describe relationship):	3a. Your Relationship to Person in Box 2: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other (please describe relationship):	
4. Mailing Address for Records:	4a: City, State, Zip Code:	

REQUEST

I am requesting that communication of personal health plan information for the person in Box 2 be provided by alternative means or at alternative locations. I **[check one (1)][am ☐ am not ☐]** making this request because disclosure of all or part of the information to which the request pertains could endanger me, or the person I represent.

Please send the information by the following alternative means:

Please send the information to the following alternative address, if different than address above:

Street address _____

City, State and Zip code _____

Phone _____

Other _____

If this request relates to communication regarding Payment for health care services, please indicate how we can reach you to discuss alternative Payment means.

_____ _____

Signature Date

SAN JOSÉ STATE UNIVERSITY

PART II – DETERMINATION OF REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF PERSONAL HEALTH PLAN INFORMATION

HUMAN RESOURCES

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DETERMINATION

After reviewing your request for Confidential Communications of personal health plan information, the Plan has made the following determination **[check one(1)]:**

☐ **Request Approved** (see Section A below).

☐ **Request Denied** (see Section B)

SECTION A: REQUEST APPROVED

The Plan accepts your written request for the use of alternative means or alternative locations for Confidential Communications of personal health plan information. The Plan will send personal health plan information **[check all that apply]**:

☐ By the alternative means you specified in Part I; and/or

☐ To the alternative address you specified in Part I.

SECTION B: REQUEST DENIED

The Plan denies your written request for the use of alternative means or alternative locations for Confidential Communications of personal health plan information for the following reasons **[check all that apply]**:

☐ The plan has determined that the request is incomplete.

☐ The Plan has determined that the request is not reasonable.

☐ The request does not clearly state that the Plan's usual means or locations of disclosure of personal health plan information poses a danger to you (or to the person in Box 2).

Name of Plan Representative	Signature of Plan Representative	Date of Determination