REQUEST FOR CONFIDENTIAL COMMUNICATIONS

hmsa
An Independent Licensee of the Blue Cross and Blue Shield Association

Please print legibly. Incomplete forms won't be processed. All sections must be completed unless otherwise specified.

PART A: INFORMATION of MEMBER REQUESTING CONFIDENTIAL COMMUNICATIONS

Last Name	First Name		MI
Address	City	State	ZIP Code
Email	Home Phone No.	Cellphone No.	
HMSA Subscriber No(s). (from your HMSA membership card; confidential communication will only apply to account(s) listed here.)		Birthdate (mm/dd/yyyy)	

PART B: REQUEST TYPE (Choose only ONE request per form)

☐ New Request ☐ Update Existing Request ☐ Revoke Request effective _____
(Date: mm/dd/yyyy)

PART C: ATTESTATION OF ENDANGERMENT (REQUIRED)

Federal privacy laws give you the right to request confidential communications to avoid endangerment. Any misrepresentation of your endangerment could subject you to fines or other penalties under federal law. **If you are a minor, this section may not apply to you. Please see PART G for more information.**

BY INITIALING THIS SECTION, I ATTEST THAT FAILURE TO COMMUNICATE MY PROTECTED HEALTH INFORMATION THROUGH ALTERNATIVE MEANS OR TO AN ALTERNATE LOCATION COULD ENDANGER ME.
(Initial here) _____

PART D: ALTERNATE COMMUNICATION INFORMATION

HMSA will send your mail to an address other than the subscriber's address or allow you to pick up your mail at an HMSA Center or office. Please choose ONE option below.

☐ **Mail all my communications to this alternate address:**

Address	City	State	ZIP Code

☐ I'll pick up **my communications at an HMSA Center or office** (Check one)

☐ HMSA Center - Honolulu ☐ HMSA Center - Hilo ☐ Kauai Office
☐ HMSA Center - Pearl City ☐ HMSA Center - Kahului

PART E: EXPIRATION

☐ Please revoke this on the following date:_____ (Date: mm/dd/yyyy)

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PART F: YOUR INDIVIDUAL RIGHTS

I understand that (please read):

HMSA will accommodate reasonable requests for me to receive communications of protected health information by alternative means or at alternate locations if I state clearly that failure to do so could endanger me. I'm not required to explain the basis for my request as a condition of confidential communications. I'm entitled to receive a copy of this signed form.

I further understand that:

- Correspondence addressed to me will be subject to confidential communications.
- Requests will be accommodated unless the alternative means for communication isn't reasonable or isn't valid.
- An incomplete form won't be processed and will be returned to me for completion.
- Confidential communications will supersede and take priority over any existing Authorized Representative requests.
- Until my account information is updated, my correspondence will continue to be mailed to the subscriber's address. Also, any checks I receive from HMSA could be sent to me but made payable to the subscriber unless I make other payment arrangements with HMSA. The health care services that I receive may be indirectly reflected on reports sent to the subscriber, such as communications about plan deductibles.
- If the subscriber or I change health plans, subscriber IDs, or employers, I'll need to resubmit this request.
- I must inform HMSA of changes to my alternate contact information. If my alternate contact information becomes invalid, HMSA will make reasonable attempts to contact me. If HMSA can't reach me, this request will expire.
- This request will expire 18 months after my health plan coverage ends or on the date specified in the "EXPIRATION" section of this form.
- If I cancel my request for confidential communications or the request expires, the restriction will be removed for all my HMSA correspondence, including information previously protected.
- If I have questions about this form, I may contact HMSA at (808) 948-6111.

PART G: YOUR SIGNATURE

I, (print member's name) _____, have had full opportunity to read and understand the contents of this form and agree to all conditions described herein.

Signature*: _____ **Date:** _____

* If signed by other than the member or if the member requiring confidential communications is less than 18 years old, a custodial parent or legal guardian/representative must sign below. (An exception may apply. See ****Exception for Minor** for more information.) **Please provide us with verification of your legal authority (e.g., member's birth certificate, medical power of attorney, legal document) to make this request on behalf of the member.**

Parent/Legal Representative's first and last names (please print): _____

Parent/Legal Representative's Email: _____ **Phone No.:** _____

Parent/Legal Representative's Signature: _____ **Date:** _____

**Exception for Minor

Exceptions may be made for certain minors (ages 14-17) in compliance with Hawaii state law if one of the following conditions is met. Please select from below:

☐ Pregnancy/Family Planning/Sexual transmitted disease ☐ Alcohol/Substance Abuse

☐ Behavioral/Mental Health

Please complete, sign, and submit this form to:
HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860. Fax: (808) 952-7580