Form F14: Confidential Communication Request

Use this form to exercise your right under federal privacy laws to request Blue Cross and Blue Shield of Vermont (BCBSVT) or The Vermont Health Plan (TVHP) to use alternative means or an alternative location when communicating with you about protected health information.

Section A: Member requesting confidential communication

Member Name: _____ Date of Birth: _____

Identification Number: _____ Telephone: _____

Subscriber's Current Address: _____

(Please do not enter alternate location information here.)

Section B: Please read the following and complete the information requested (this is a two page form)

You have the right to request that we communicate your protected health information by alternative means or to an alternative location to avoid endangering you. We will accommodate your request if (a) it is reasonable, (b) you state clearly that failure to communicate your protected health information by the alternative means or to the alternative location could endanger you, (c) you provide reasonable alternative means or location for communicating with you, and (d) a satisfactory explanation how any applicable premium or other payments will be handled under the alternative means or location you request. To exercise this right, please complete this Section B. Attach additional pages if necessary.

I assert that failure to communicate about my protected health information by an alternative means or to an alternative location could endanger me for the following reasons:

Please describe the protected heath information you want to be subject to confidential communication:

Please explain how any applicable premium or other payments will be handled:

Please complete one of the following:

☐ I request that you communicate with me about my protected health information by the following alternative means. Please provide full information on the alternative means you want us to use:

☐ I request that you communicate with me about my protected health information at the following alternative location. Please provide full information on the alternative location (e.g. address, telephone number):

Section C: Individual's signature

I attest that all of the above statements on this request and all information furnished by me are true and complete to the best of my knowledge.

Signature: _____ Date: _____

If you are a personal representative, such as a Legal Guardian or agent acting under a Power of Attorney, you *may* be able to sign on behalf of the Member/Patient if the supporting paperwork has required regulatory language. Complete the following and attach documentation (if applicable) supporting such personal representation and our Legal department will determine whether it is sufficient to grant authorization:

Personal Representative's Name: _____

Relationship to Individual: _____

Please keep a copy of this document for your records and email the completed Confidential Communication Request to Blue Cross and Blue Shield of Vermont, Attn: Privacy Officer, at CustomerService@bcbsvt.com.

NOTE: This form must be signed and sent by the Member granting the permission, not the person receiving the permission.