Confidential Communications Request
Confidentiality of Medical Information Act

TO: Inland Empire Health Plan (IEHP)

FROM: _____
Member First and Last Name (Required)

_____
Date of Birth (Required)

_____
Last four digits of SS#, Medi-Cal ID # or IEHP Member ID # (Required)

I request to change my contact information for any communication about my medical information, including sensitive services, I receive with IEHP.

"Medical information" means any individually identifiable information (electronic or physical) in possession of or derived from a health care provider, health care plan, pharmaceutical company, or contractor about a patient's health record, mental health application information, mental or physical state, or treatment. "Individually identifiable" means that the medical information has personal information, such as the patient's name, address, email, phone number, social security number, or other information that, alone or with other public information, reveals their identity. It may also include notices of action, notice of grievance or appeal resolution, care plans, health care and visit reminders.

"Sensitive services" include sexual and reproductive health care, mental health, sexual assault counseling and care, gender-affirming care, domestic violence care, and alcohol and drug use treatment (California Civil Code § 56.05).

I request IEHP and our delegates send <u>all medical information, including sensitive services,</u> to me at the alternate address below:

U.S. Mailing Address (Required): _____

Email Address: _____

Phone Number (Required): _____

This request is valid until I submit a revocation or new request.

I understand I will get a confirmation letter for my request at the address above.

For communication from my doctor's office, I must give them the alternate address.

Signature (Required): _____ Date: _____

Questions or concerns?
Call IEHP Member Services at 1-800-440-IEHP (4347), Monday-Friday, 7am-7pm, and Saturday Sunday, 8am-5pm. TTY users should call 1-800-718-4347.

Please return this request to one of the following:

- **Email:** memberservices@iehp.org
- **Mail:** IEHP Member Services
  P.O. Box 1800
  Rancho Cucamonga, CA 91729
- **Fax:** (909) 890-5877 or (909) 477-8546

Revocation of Confidential Communications Request

Fill out this section to end the delivery of confidential communications, including sensitive services, at the alternate address, email address or phone number given before.

TO: Inland Empire Health Plan (IEHP)

FROM: _____
Member Name

_____ _____
Date of Birth Member ID #

I understand this request ends confidential communication being sent to my alternate address. My medical information will no longer be sent to the previous alternate address as of the date signed below.

Signature: _____ **Date:** _____

Questions or concerns?
Call IEHP Member Services at 1-800-440-IEHP (4347), Monday-Friday, 7am-7pm, and Saturday Sunday, 8am-5pm. TTY users should call 1-800-718-4347.

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