Confidential Communications Request

Mail to: Landmark Healthplan of California,
2629 Townsgate Rd. Westlake Village, CA 91361

Fax to: 800 337 7211

Email to: groupservices@lhp-ca.com
Include in Subject Line: Confidential Communications Request

Questions? 800 298 4875

Member Name (First, Last) _____

Date of Birth _____

Street Address _____ City, State, Zip _____

Phone Number _____

This request is: Check [✓] one   -   NEW   -   MODIFIED
- TO REVOKE an existing request effective (indicate date) _____ Skip to Revocation

I am contacting you to request that my medical information be delivered by alternate means or to an alternate address below for the following reason(s): Check [✓] one or both

[ ]   My medical information relates to sensitive services. ("Sensitive services" include sexual and reproductive health care, mental health, sexual assault counseling and care and treatment for alcohol and drug use.)

[ ]   Disclosure of my medical information could endanger me or subject me to harassment or abuse.
(You will never be asked to explain this.)

Alternative Means or Alternate address: Landmark will send your medical information to one of the options below. Check [✓] the option(s) that are safe for you to receive information. If you check more than one option, indicate a "1" next to your first choice, "2" next to your second choice and so on. Include email or mailing address in the space provided.

option # _____ - EMAIL to: _____

option # _____ - MAIL to: Street Address _____

City, State, Zip _____

option # _____ - OTHER: _____

I understand and agree to the following:

- Landmark will send all of my medical information to this address.
- I must notify Landmark if I wish to change this information. This request is valid until I submit a revocation or a new request.
- This form will affect only communications from Landmark. If I also wish my employer, physician or anyone outside of Landmark to make this change, you must contact them directly. (Call Customer Service for contact information for these entities).
- This request will expire eighteen (18) months after my benefits coverage has terminated.

Revocation: If I have indicated this is a **revocation** above, revoke my confidential communications request and use the following address for all of my medical information.

Street Address _____ City, State, Zip _____

_____

MEMBER NAME (PRINT)   MEMBER SIGNATURE   DATE

Landmark Internal Use Only   Date Request Received ___

Member Identification verified (list documents checked/reviewed _____

If request was received by phone: Date_____ Time_____ Date Request Fulfilled _____

_____

MANAGER OR SUPERVISOR NAME (PRINT)   MANAGER OR SUPERVISOR SIGNATURE   DATE