

MEBS, INC.

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Participant Name: _____ DOB: ____ / ____ / ____
MM / DD / YR

Address: _____

Home Telephone Number: _____ E-mail: _____

Participant Identification Number and/or Social Security Number: _____

I, _____, am requesting that MEBS communicate with me in the alternative manner and/or location described below regarding my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996). Such restriction is necessary to prevent a disclosure that could endanger me. I understand that MEBS may deny this request if it imposes an unreasonable administrative burden.

Description of the Health Information that Must be Communicated Confidentially. The following is a description of the specific health information to which this request applies:

Alternative Manner and/or Location. I request that MEBS only communicate with me in the following manner and/or at the location described below:

By signing this form, I am confirming that it accurately reflects my wishes.

Signature Date

If signed by personal representative:

Name of personal representative: _____

Relationship to participant or nature of authority: _____

Signature of Personal Representative Date

Submit Form to: Privacy Officer, MEBS, 3809 Lake Eastbrook Blvd., Grand Rapids, MI 49546