Confidential Communications Request Form

CalViva Health wants you to know that you have a choice about your protected health information (PHI). You can have CalViva Health send any communication that has PHI directly to you.*

California law states: "Sensitive Services means: all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence."

PHI is health information about you. Examples of communications that include PHI are:

- Information about your appointments.
- Information about treatment or services you may have asked for.
- The name and address of your provider, descriptions of services provided and other visit information.

***Note:** The choice to request PHI to remain private only applies to members who have the right to consent to care. Please refer to the CalViva Health Member Handbook for more information about minor consent. If you are over the age of 12, you do not need approval from your parent, guardian or personal representative to make the Confidential Communication Request.

Complete this form if you'd like us to send communications that contain PHI directly to you.

Please mail or fax this finished form to CalViva Health.

ALLOW UP TO 14 DAYS FOR US TO PROCESS YOUR REQUEST.

Mail: CalViva Health – Privacy Office:
7625 N. Palm Ave., Suite 109, Fresno, CA 93711

Fax: (559) 446-1998, Attention: CalViva Health Privacy Office

Tip!

If you change your enrollment to another plan, you will need to complete this form again under your new member ID Number.

WE'RE HERE TO HELP!
Please call or email us if you have questions.

Phone: Refer to the phone number on the back on your member ID card.

Email: Privacy@CalVivaHealth.org

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CalViva HEALTH℠

Your information:		
First name:	Last name:	Birthdate:
Member ID number:	Phone number: *Where we can call you if we have questions?*	

Yes! Please send communications with my PHI to this mailing address:		
Mailing address:		
City:	State:	ZIP:

I certify and acknowledge that the above information is true and correct.	
Signature:	Date:

Note: The Confidential Communications Request shall be valid until the member submits a revocation of the request. Or, until a new Confidential Communications Request is submitted.

If you are signing for the member, describe your relationship below. If you are the member's personal representative, describe this below. And, send us copies of those forms (such as Power of Attorney or Order of Guardianship).

I certify and acknowledge that the above information is true and correct.
Personal Representative Name: (Please print)

Describe the relationship:
Relationship to the member: (Please print)

Personal representative signature:	
Signature:	Date: