Confidential Communications Revocation Request Form

I want to cancel or revoke the Confidential Communication Request I gave to CalViva Health. This is in regard to:

- All messaging, alerts, etc.
- Medical information
- Sensitive services

This is to take effect as of the date of my signature below.

Your information		
First name:	Last name:	Birthdate:
Subscriber ID number:	Phone number: *Where we can call you if we have questions?*	
Mailing address:		
City:	State:	ZIP:

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."

Health information includes:

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

I understand that this cancellation request only applies to health information being sent to the mailing address on my Communication Request form. I also understand that before this cancelation request, some health information may have already been sent to the address I had given on the form.

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

(continued)

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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 attest and acknowledge that the above information is true and correct.	
Personal representative name: (Please print)	
Please describe the relationship:	
Relationship to the member: (Please print)	
Personal representative signature:	
Signature:	Date:

CalViva Health will stop using or sharing your health information when we receive and process this form. Use the mailing address below. You can also call for help at the number below.

Please mail or FAX this completed 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