



Request for Confidential Communications of Protected Health Information (PHI)

I hereby request that all information relating to the Treatment described below, and to Payment for that Treatment be sent to me only at the following address:

Participant Name: _____ **Date of Birth:** _____

Address: _____ **Telephone:** _____

Participant Social Security Number: _____

Dates of Treatment: _____

Name and Address of Health Care Provider: _____

Describe how Payment for the above Treatment will be handled:

I affirm that disclosures of any part of the information relating to this Treatment to any other address will endanger me.

I understand that this request applies only to the Cement Masons Health and Welfare Trust Fund for Northern California, Health and Welfare Plan, and that I may request similar confidential communications from my health care providers.

I understand that the Cement Masons Health and Welfare Trust Fund for Northern California, Health and Welfare Plan must only accommodate reasonable requests. Accordingly, the Cement Masons Health and Welfare Trust Fund for Northern California, Health and Welfare Plan may deny this request if it determines the request to be unreasonable.

I understand that any false statement on this request constitutes fraud under federal law, and may be punishable as a criminal offense.

Signed: _____ Date: _____
Signature of Participant

If the request is approved, a copy of the request shall be sent to the appropriate Team Members and a copy of the request shall be maintained in the benefit file of the participant.

